

90 26501

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ronald H. Marts Roland H. Marts</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9/21/90</b>  |  | 3. TIME OF DEATH<br><b>6:33 PM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-18-2262</b>  |  | 5. SEX<br><b>1 M 2 F</b>  |  | 6. AGE (In yrs. last birthday)<br><b>66</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>AUG. 16, 1924</b>             |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Church Hospital Corporation</b>   |  |   |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 8c. COUNTY OF DEATH<br><b>BALTO. MD.</b>                                   |  |
| 9a. STATE<br><b>Md.</b>  |  |   |  | 9b. COUNTY<br><b>-</b>  |  | 9c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>                        |  |
| 10a. STREET AND NUMBER<br><b>2705 e. fayette ST.</b>   |  |   |  | 10b. ZIP CODE<br><b>21224</b>   |  | 10c. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                             |  |
| 11. MARITAL STATUS<br><b>1 Never Married 2 Married</b><br><b>3 Widowed 4 Divorced</b>  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><b>1 YES 2 NO</b><br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 NO</b> Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b> |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>9th</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>OFFICE WORKER</b> |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>RAYMOND RICHARD MARTS</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>EVELYN LOUISA BECKER</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>FAMILY RECORDS</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>SAME AS ABOVE</b>                         |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 Burial 2 Cremation 3 Removal from State</b><br><b>4 Donation 5 Other (Specify)</b>  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MCKELAND MEM. PARK PARKVILLE, MD.</b>                    |  | 20c. LOCATION — City or Town, State   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>John L. Gair</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>EVANS CHAPEL OF MEMORIALS<br/>3800 HARFORD RD.</b>   |  |  |  |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. COLON CARCINOMA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. HYPOTENSION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 NO</b>  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 NO</b>  |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b> |
| 27. MANNER OF DEATH<br><b>1 Natural 5 Pending Investigation</b><br><b>2 Accident 8 Could not be determined</b><br><b>3 Suicide 4 Homicide</b>  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>                                  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>S. Smith M.D.</b>   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/21/90</b>                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Ibarra Irene MD. Church hospital</b>   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 3

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician. After this certificate has been signed by the attending physician, it should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SECRET



90 26502

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br>Rita Lenore Monfredo   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>September 25, 1990   |  | 3. TIME OF DEATH<br>M  |  |
| 4. SOCIAL SECURITY NUMBER<br>220-09-0079   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>70 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>June 17, 1920   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Md   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>6812 Old Harford Road  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore   |  |
| 9c. COUNTY OF DEATH<br>City  |  |  |  | 10a. STATE<br>Md.  |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>6812 Old Harford Road  |  |
| 10f. ZIP CODE<br>21234   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5 +)   |  |  |  | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Gett Smith  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anna -  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Nicholas M. Monfredo   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6812 Old Harford Road Baltimore, Md 21234   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Crypt   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Oak Lawn Sept. 28, 1990  |  | 20c. LOCATION — City or Town, State<br>Baltimore, Md. 21224  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>James F. Gladden  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Leonard J. Ruck Inc. 5305 Harford Rd.  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → GENERALIZED CARCINOMATOSIS.<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF): CHOLANGIOCARCINOMA (KELATKINS TUMOR).<br>b. DUE TO (OR AS A CONSEQUENCE OF): ANEMIA, SECONDARY.<br>c. DUE TO (OR AS A CONSEQUENCE OF): ARTERIO SCLEROTIC HEART DISEASE.<br>d. |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Rubin Sebastian, M.D.   |  |  |  | 29c. LICENSE NUMBER<br>D-10397   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/25/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Rubin Sebastian MD 2314 E. Joppa Road Baltimore, Md.  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 27 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

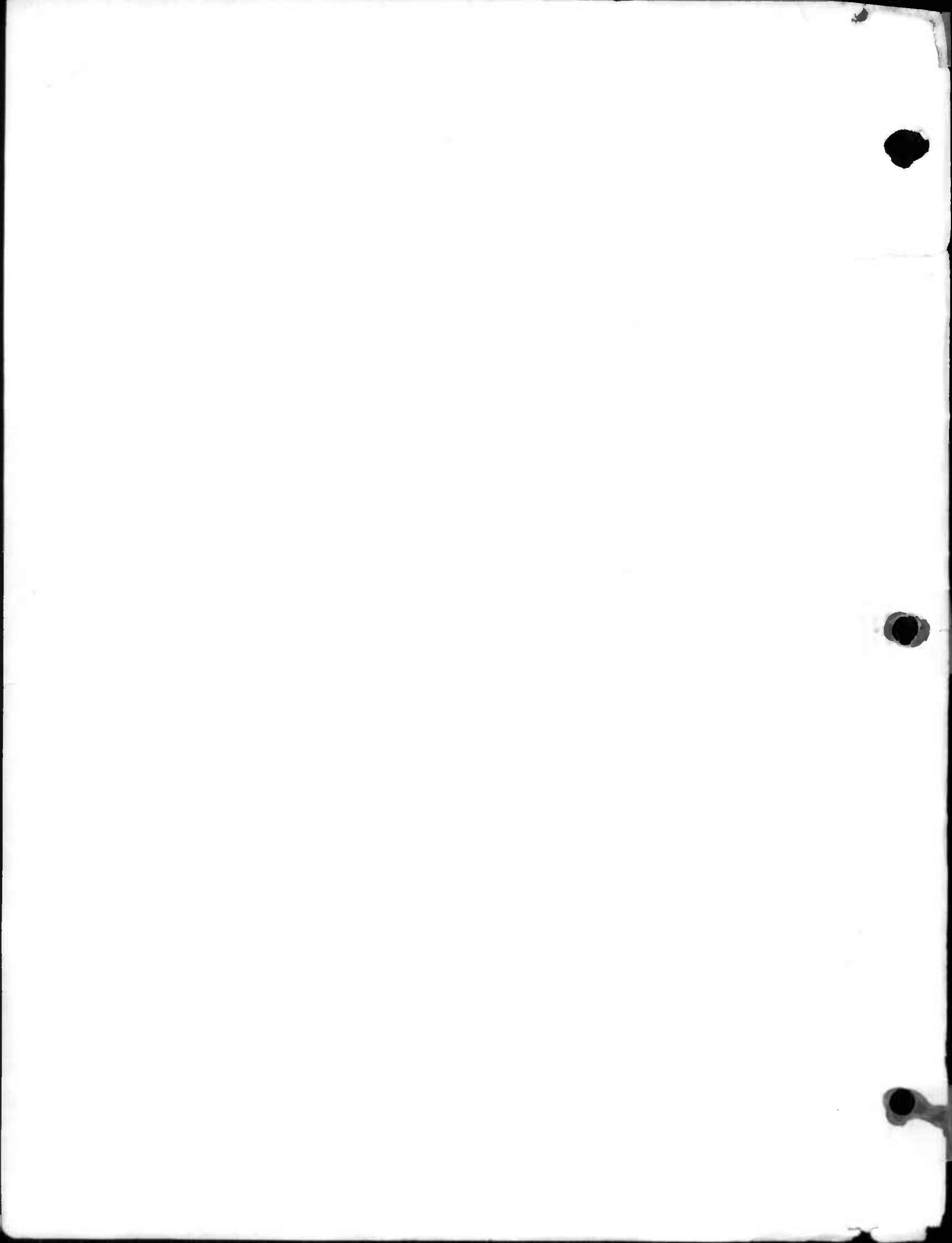
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26503

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HARRY WALTER MENTZER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 24 1990</b>  |  | 3. TIME OF DEATH<br><b>2:45 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-09-1255</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept 27 1919</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>G.B.M.C. CHARLES STREET</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>   |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b>   |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>PARKTON</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>1104 MT CARMEL RD</b>   |  |
| 10f. ZIP CODE<br><b>21120</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II Army</b>  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 8+) <b>College</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Food Service-Self Ret.</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Harry C. Mentzer</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Annie Stenger</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Anita E. Mentzer</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1104 Mt. Carmel Rd. Parkton, Maryland 21120</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Green Mount Cem. 9/26/90</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore Maryland</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Milton J. Knight Jr</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leonard J. Ruck, Inc. 5305 Harford Road</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CHRONIC OBSTRUCTIVE AIRWAYS DISEASE WITH EXACERBATION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>J. A. Riley, MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D25205</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/25/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>G B M C</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

For the year 1911

90 26504

(4:00 pm)

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>John Francis Nee   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9 25 90  |  | 3. TIME OF DEATH<br>4:00 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>219-22-8847   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>62 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Feb. 8, 1928   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Md.  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>CHURCH HOSPITAL  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE MD  |  |
| 9c. COUNTY OF DEATH<br>city  |  |  |  | 10a. STATE<br>Md.  |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br>Baltimore City  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>4815 Apt. D N Bayonne Avenue   |  |
| 10f. ZIP CODE<br>21206   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW II   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: X  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Sales   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Thomas Nee  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Delia Catherine King  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Lena G. Nee  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4515 Shamrock Avenue Baltimore, Md. 21206   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Garrison Forest Veterans Sept. 29, 1990  |  | 20c. LOCATION — City or Town, State<br>Owings Mills, Md.   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>James F. Gladden James F. Gladden   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Leonard J. Ruck Inc. 5305 Harford Rd. 21214  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA / Respiratory failure<br>DUE TO (OR AS A CONSEQUENCE OF):<br>CVA<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>METABOLIC ENCEPHALOPATHY<br>EXTREME WEIGHT LOSS |  |  |  |  |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28e. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Terance L. Lamb (Hospital physician)  |  |  |  | 29c. LICENSE NUMBER<br>D37203  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-25-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>TERANCE L. LAMB CHURCH HOSPITAL BALTIMORE, MD   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 27 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEMS:23,27 per ME  
G-668 10-16-90 cm

90 26505

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Jill McShane Nosker   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-16-90   |  | 3. TIME OF DEATH<br>2:10PM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>231-33-9558  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>20 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>5/14/1970  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Indiana   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Peninsula General Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Salisbury   |  |
| 9c. COUNTY OF DEATH<br>Wicomico County  |  |  |  | 10a. STATE<br>Virginia  |  | 10b. COUNTY<br>Fairfax   |  |
| 10c. CITY, TOWN OR LOCATION<br>Vienna   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>2725 Bowling Green Court   |  |
| 10f. ZIP CODE<br>22180  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>1  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Student  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>NOVA Annandale Campus  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>James Francis Nosker   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Lois Marian Spriggs Cioletti   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>James Francis Nosker  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2725 Bowling Green Court Vienna, Va. 22180   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Fairfax Memorial Park   |  | 20c. LOCATION — City or Town, State<br>Fairfax, Virginia   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Donald E. Price  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Lee Funeral Home<br>8521 Sudley Road Manassas, Virginia 22110   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIOMYOPATHY</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  |  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER<br>(Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Margaret A. Korell   |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-17-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARGARITA A. KORELL, MD 111 Penn Street, Baltimore, MD 21201   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 27 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26506

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <u>SWINSON</u><br><u>ROSA L. PERRY</u>   |  |  |  | 2. DATE OF DEATH<br>MONTH <u>9</u> DAY <u>22</u> YEAR <u>90</u>  |  | 3. TIME OF DEATH<br><u>9:15 AM</u>   |   |
| 4. SOCIAL SECURITY NUMBER<br><u>216-24-9603</u>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><u>62</u> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>07-12-1928</u>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>Va</u>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><u>Univ. of Maryland</u>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Baltimore</u>  |   |
| 9c. COUNTY OF DEATH<br><u>Balt</u>  |  |  |  | 10a. STATE<br><u>MD</u>  |  | 10b. COUNTY<br><u>Baltimore</u>  |   |
| 10c. CITY, TOWN OR LOCATION<br><u>Baltimore</u>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><u>1841 Druid Hill Ave</u>   |   |
| 10f. ZIP CODE<br><u>21217</u>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>Black</u>  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>9th</u> College (1-4 or 5+) <u></u>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Willie Lewis</u>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Eulah Nickens</u>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Jule B. Perry</u>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>1841 Druid Hill Ave Baltimore MD 21217</u>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Arbutus Mem Park</u>  |  | 20c. LOCATION — City or Town, State<br><u>Arbutus, Md</u>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Dean B. Cyle</u>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>March 4500 Wabash Ave</u>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Respiratory Failure</u>  |  |  |  |  |  |  | <u>&lt;1 hour</u>   |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |   |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |  |  |  |   |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Coronary Artery Disease</u><br><u>End Stage Renal Disease</u>  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Fernando Rabeon MD</u>   |  | 29c. LICENSE NUMBER  |   |
| 29d. DATE SIGNED (Month, Day, Year)<br><u>9/22/90</u>   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>F. L. Rabeon 22 S. Greene St. Baltimore MD 21201</u>   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><u>SEP 27 1990</u>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26507

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |                                |   |  |
|--|--|--|--|---|--------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JACIE PAYNE</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 17 90</b>   |                                | 3. TIME OF DEATH<br><b>12 45 M</b>  |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>02 28 02</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Leland Memorial Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Riverdale, Md.</b>  |                                | 9c. COUNTY OF DEATH<br><b>Prince Georges</b>  |  |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Prince Georges</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Hyattsville MXXXX</b>   |                                | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>6500 Riggs Rd.</b>  |  |  |  | 10f. ZIP CODE<br><b>20783</b>   |                                | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 8+)   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY  |                                |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Payne</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |                                |   |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |                                |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>in-state cem.</b>   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | 20c. LOCATION — City or Town, State   |                                |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board Balto. Md.</b>   |                                |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrhythmia</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {<br>a. DUE TO (OR AS A CONSEQUENCE OF): <b>Congestive heart failure</b><br>b. DUE TO (OR AS A CONSEQUENCE OF): <b>Sepsis</b><br>c. DUE TO (OR AS A CONSEQUENCE OF): <b>Urinary tract infection</b><br>d. |  |  |  |   |                                | Approximate interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |                                | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  |  |  |   |                                | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |                                |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |                                | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |                                |   |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |                                |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |                                |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> M.D.   |  |  |  | 29c. LICENSE NUMBER   |                                | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-17-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |   |                                |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |                                |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26508

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ELIZABETH N. PATTERSON</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>22</b> YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>5:30 P.</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>726-09-1905</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>OCT. 22, 1902</b>                              |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>WILSON HEALTH CARE CENTER</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>GAITHERSBURG, MD</b>  |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |   |
| 10a. STATE<br><b>MD.</b>  |  |  |  | 10b. COUNTY<br><b>MONTGOMERY</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>GAITHERSBURG</b>  |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>211 RUSSELL AVE.</b>   |  |   |   |
| 10f. ZIP CODE<br><b>20877</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>0</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>POST EXCHANGE CLERK</b>  |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>WALTER REED HOSPITAL</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WILLIAM HENRY NORRIS</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY ADELAID WALKER</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>D. STEWART PATTERSON</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>SAME AS # 10</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>METROPOLITAN CREMATORY</b>  |  | 20c. LOCATION — City or Town, State<br><b>ALEXANDRIA, VA.</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Muriel H. Barber</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MURIEL H. BARBER FUNERAL HOME</b><br><b>21525 LAYTONSVILLE RD. LAYTONSVILLE, MD. 20882</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>sepsis</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Alzheimer's disease</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John R. Melnich</i> MD  |  |  |  | 29c. LICENSE NUMBER<br><b>D19294</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/23/90</b>                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JOHN R. MELNICH 911 RUSSELL AVE GAITHERSBURG MD 20879</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for processing burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or a traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mary Susan Ouattro</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9-17-90</b>  |  | 3. TIME OF DEATH<br><b>10:17AM</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-36-5431</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>58 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>05-28-32</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>3411 Lake Montebello Drive</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>MD</b>  |  |  |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>3411 Lake Montebello Drv.</b>  |  |  |  |
| 10f. ZIP CODE<br><b>21218</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>RN</b>                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>State Hosp.</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Garland Yeager</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elizabeth Davis</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lauren Quattro</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2846 Lake Ave. Balto. Md. 21213</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | 20c. LOCATION — City or Town, State   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Brd. Balto. Md.</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Multiple cutting wounds of left arm</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 26a. DATE OF INJURY (Month, Day, Year)<br><b>FOUND: 9-17-90</b>  |  | 26b. TIME OF INJURY<br><b>M</b>   |  | 26c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 26d. DESCRIBE HOW INJURY OCCURRED<br><b>Self inflicted wounds</b>  |  | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>3411 Lake Montebello Drive, Baltimore, MD</b>  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-18-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>FRANK PERETTI, MD 111 Penn Street, Baltimore, MD 21201</b> vc  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b> 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26510

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DUDLEY THOMAS QUIMBY</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPTEMBER 20, 1990</b>   |  | 3. TIME OF DEATH<br><b>9:15 AM</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>220188387</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>64RS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12-07-25</b>                            |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SACRED HEART HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CUMBERLAND, MARYLAND</b>  |  | 9c. COUNTY OF DEATH<br><b>ALLEGANY</b>  |   |
| 10a. STATE<br><b>WV.</b>  |  |  |  | 10b. COUNTY<br><b>Three Churches</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Three Churches</b>                              |   |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>Star Rt. 1 Box 12 A-1</b>  |  |   |   |
| 10f. ZIP CODE<br><b>26765</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |   |   |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>           |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Engineer</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>N.A.S.A.</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Hilda Quimby</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Star Rt-1 Box 12 A-1 Three Churches, WV. 26765</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | 20c. LOCATION — City or Town, State   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Donald A. Wance</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Brd. Balto. Md.</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Ca of colon with widespread metastases</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Marked ascites</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>6 wks.</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John H. Mehan</i> M.D.  |  |  |  | 29c. LICENSE NUMBER<br><b>D-17526</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-20-90</b>                             |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. JOHN MEHANNA, M.D., 909-B SETON DRIVE, CUMBERLAND, MARYLAND 21502</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


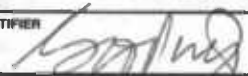
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26511

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |   |  |  |
|---|--|--|--|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LOUIS RICE</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>25</b> YEAR <b>90</b>   |   | 3. TIME OF DEATH<br><b>1:40A</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>246-05-5886</b>   |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>68</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10-10-21</b>   | 8. BIRTHPLACE (State or Foreign Country)<br><b>South Carolina</b> |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Liberty Medical Center</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |   | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY  |   | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                            |  |
| 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |   |  |  |
| 10e. STREET AND NUMBER<br><b>2303 Monroe Street</b>   |  |  |  | 10f. ZIP CODE<br><b>21217</b>  |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                           |  |
| 11. MARITAL STATUS<br><b>3</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>World War II</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO Specify: |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b> |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Chauffer</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Maryland Dry Dock</b>   |   |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Rice</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Measie Curns</b>   |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Stan Rice</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8829 Meadow Heights Rd. Randallstown, MD 21133</b>   |   |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Garrison MD Veteran Cemetery/Forest Owings Mills, MD</b>  |  | 20c. LOCATION — City or Town, State  |   |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Nutter Funeral Homes, 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>   |   |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>SEPSIS</b><br><b>DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>METASTATIC LUNG CANCER</b><br><b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br><b>DIABETES MELLITUS</b> |  |  |  |  |   |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES MELLITUS</b>  |  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br><b>HOSPITAL:</b><br><b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br><b>OTHER:</b><br><b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>6</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide <b>5</b> <input type="checkbox"/> Could not be determined |  |  |   |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |   | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |   |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D 23300</b>  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-25-90</b>                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SUDHIR D. PATEL 2606 Liberty Medical Center Liberty Rd. BALTO MD 21215</b>  |  |  |  |  |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>   |  |  |  |  |   |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for filing. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

117

2001

2

111

2001

111

111

111



90 26512

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>James M. Robinson, Jr  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept 18 1990  |  | 3. TIME OF DEATH<br>4:44 PM  |   |
| 4. SOCIAL SECURITY NUMBER<br>215-28-1257   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>59 YRS.   |  | 7. DATE OF BIRTH (Month/Day/Year)<br>8/16/31   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Md.  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>3403 JoAnn Drv.   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE                                     |   |
| 9c. COUNTY OF DEATH  |  |  |  |   |  |  |   |
| 10a. STATE<br>MD   |  |  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE   |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |   |
| 10e. STREET AND NUMBER<br>3403 JOAnn Drv BALTIMORE   |  |  |  | 10f. ZIP CODE<br>21207  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black                  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>College Degree  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Claims Examiner                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Government  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>James Robinson Sr.  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Florence Hackett, B.   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Tyrone Barber, S.  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3130 Lugine Ave. Balto. Md. 21207  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>State Anatomy Board  |  | 20c. LOCATION — City or Town, State<br>Baltimore, Md  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>March F/H West<br>4300 Wabash Avenue  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CANCER BRITIFORM SINUS<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br>2 YRS   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>KM Tins MD  |  |  |  | 29c. LICENSE NUMBER<br>D20333   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/24/90                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>KZOMIES MD 122 SLADE AVE BALTIMORE MD 21208   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 27 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 1346, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.

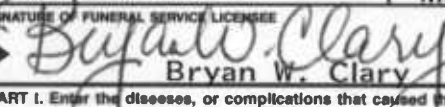

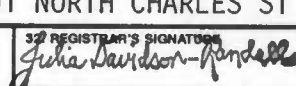
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

9127 4

90 26513

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |  |
|--|--|--|--|---|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CATHERINE J. RECKORD</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>25</b> YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>3:10 P</b> <b>M</b>   |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>222-03-9879</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>3 31 1918</b>                              |   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>VIRGINIA</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>G.B.M.C. 6701 N. CHARLES STREET</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TOWSON</b>                                 |   |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |  |  |   |  |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>TOWSON</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br><b>212 BOSLEY AVE</b>  |  |  |  | 10f. ZIP CODE<br><b>21204</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>              |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Homemaker</b>  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Carl Oswald Jockel</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Alice Richardson</b>  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Henry B. Reckord</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>212 Bosley Ave., Towson, Md. 21204</b>  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>   |  | 20c. LOCATION — City or Town, State<br><b>Catonsville, Md.</b>  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><br><b>Bryan W. Clary</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lemmon-Mitchell-Wiedefeld<br/>Timonium, Maryland 21093</b>   |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>GI BLEED</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. <b>CVA</b><br>c.<br>d.<br>e.<br>f.<br>g.<br>h.<br>i.<br>j.<br>k.<br>l.<br>m.<br>n.<br>o.<br>p.<br>q.<br>r.<br>s.<br>t.<br>u.<br>v.<br>w.<br>x.<br>y.<br>z.<br>aa.<br>ab.<br>ac.<br>ad.<br>ae.<br>af.<br>ag.<br>ah.<br>ai.<br>aj.<br>ak.<br>al.<br>am.<br>an.<br>ao.<br>ap.<br>aq.<br>ar.<br>as.<br>at.<br>au.<br>av.<br>aw.<br>ax.<br>ay.<br>az.<br>ba.<br>bb.<br>bc.<br>bd.<br>be.<br>bf.<br>bg.<br>bh.<br>bi.<br>bj.<br>bk.<br>bl.<br>bm.<br>bn.<br>bo.<br>bp.<br>bq.<br>br.<br>bs.<br>bt.<br>bu.<br>bv.<br>bw.<br>bx.<br>by.<br>bz.<br>ca.<br>cb.<br>cc.<br>cd.<br>ce.<br>cf.<br>cg.<br>ch.<br>ci.<br>cj.<br>ck.<br>cl.<br>cm.<br>cn.<br>co.<br>cp.<br>cq.<br>cr.<br>cs.<br>ct.<br>cu.<br>cv.<br>cw.<br>cx.<br>cy.<br>cz.<br>da.<br>db.<br>dc.<br>dd.<br>de.<br>df.<br>dg.<br>dh.<br>di.<br>dj.<br>dk.<br>dl.<br>dm.<br>dn.<br>do.<br>dp.<br>dq.<br>dr.<br>ds.<br>dt.<br>du.<br>dv.<br>dw.<br>dx.<br>dy.<br>dz.<br>ea.<br>eb.<br>ec.<br>ed.<br>ee.<br>ef.<br>eg.<br>eh.<br>ei.<br>ej.<br>ek.<br>el.<br>em.<br>en.<br>eo.<br>ep.<br>eq.<br>er.<br>es.<br>et.<br>eu.<br>ev.<br>ew.<br>ex.<br>ey.<br>ez.<br>fa.<br>fb.<br>fc.<br>fd.<br>fe.<br>ff.<br>fg.<br>fh.<br>fi.<br>fj.<br>fk.<br>fl.<br>fm.<br>fn.<br>fo.<br>fp.<br>fq.<br>fr.<br>fs.<br>ft.<br>fu.<br>fv.<br>fw.<br>fx.<br>fy.<br>fz.<br>ga.<br>gb.<br>gc.<br>gd.<br>ge.<br>gf.<br>gg.<br>gh.<br>gi.<br>gj.<br>gk.<br>gl.<br>gm.<br>gn.<br>go.<br>gp.<br>gq.<br>gr.<br>gs.<br>gt.<br>gu.<br>gv.<br>gw.<br>gx.<br>gy.<br>gz.<br>ha.<br>hb.<br>hc.<br>hd.<br>he.<br>hf.<br>hg.<br>hi.<br>hj.<br>hk.<br>hl.<br>hm.<br>hn.<br>ho.<br>hp.<br>hq.<br>hr.<br>hs.<br>ht.<br>hu.<br>hv.<br>hw.<br>hx.<br>hy.<br>hz.<br>ia.<br>ib.<br>ic.<br>id.<br>ie.<br>if.<br>ig.<br>ih.<br>ii.<br>ij.<br>ik.<br>il.<br>im.<br>in.<br>io.<br>ip.<br>iq.<br>ir.<br>is.<br>it.<br>iu.<br>iv.<br>iw.<br>ix.<br>iy.<br>iz.<br>ja.<br>jb.<br>jc.<br>jd.<br>je.<br>jf.<br>jg.<br>jh.<br>ji.<br>jj.<br>jk.<br>jl.<br>jm.<br>jn.<br>jo.<br>jp.<br>jq.<br>jr.<br>js.<br>jt.<br>ju.<br>jv.<br>jw.<br>jx.<br>jy.<br>jz.<br>ka.<br>kb.<br>kc.<br>kd.<br>ke.<br>kf.<br>kg.<br>kh.<br>ki.<br>kj.<br>kk.<br>kl.<br>km.<br>kn.<br>ko.<br>kp.<br>kq.<br>kr.<br>ks.<br>kt.<br>ku.<br>kv.<br>kw.<br>kx.<br>ky.<br>kz.<br>la.<br>lb.<br>lc.<br>ld.<br>le.<br>lf.<br>lg.<br>lh.<br>li.<br>lj.<br>lk.<br>ll.<br>lm.<br>ln.<br>lo.<br>lp.<br>lq.<br>lr.<br>ls.<br>lt.<br>lu.<br>lv.<br>lw.<br>lx.<br>ly.<br>lz.<br>ma.<br>mb.<br>mc.<br>md.<br>me.<br>mf.<br>mg.<br>mh.<br>mi.<br>mj.<br>mk.<br>ml.<br>mm.<br>mn.<br>mo.<br>mp.<br>mq.<br>mr.<br>ms.<br>mt.<br>mu.<br>mv.<br>mw.<br>mx.<br>my.<br>mz.<br>na.<br>nb.<br>nc.<br>nd.<br>ne.<br>nf.<br>ng.<br>nh.<br>ni.<br>nj.<br>nk.<br>nl.<br>nm.<br>nn.<br>no.<br>np.<br>nq.<br>nr.<br>ns.<br>nt.<br>nu.<br>nv.<br>nw.<br>nx.<br>ny.<br>nz.<br>oa.<br>ob.<br>oc.<br>od.<br>oe.<br>of.<br>og.<br>oh.<br>oi.<br>oj.<br>ok.<br>ol.<br>om.<br>on.<br>oo.<br>op.<br>oq.<br>or.<br>os.<br>ot.<br>ou.<br>ov.<br>ow.<br>ox.<br>oy.<br>oz.<br>pa.<br>pb.<br>pc.<br>pd.<br>pe.<br>pf.<br>pg.<br>ph.<br>pi.<br>pj.<br>pk.<br>pl.<br>pm.<br>pn.<br>po.<br>pp.<br>pq.<br>pr.<br>ps.<br>pt.<br>pu.<br>pv.<br>pw.<br>px.<br>py.<br>pz.<br>qa.<br>qb.<br>qc.<br>qd.<br>qe.<br>qf.<br>qg.<br>qh.<br>qi.<br>qj.<br>qk.<br>ql.<br>qm.<br>qn.<br>qo.<br>qp.<br>qq.<br>qr.<br>qs.<br>qt.<br>qu.<br>qv.<br>qw.<br>qx.<br>qy.<br>qz.<br>ra.<br>rb.<br>rc.<br>rd.<br>re.<br>rf.<br>rg.<br>rh.<br>ri.<br>rj.<br>rk.<br>rl.<br>rm.<br>rn.<br>ro.<br>rp.<br>rq.<br>rr.<br>rs.<br>rt.<br>ru.<br>rv.<br>rw.<br>rx.<br>ry.<br>rz.<br>sa.<br>sb.<br>sc.<br>sd.<br>se.<br>sf.<br>sg.<br>sh.<br>si.<br>sj.<br>sk.<br>sl.<br>sm.<br>sn.<br>so.<br>sp.<br>sq.<br>sr.<br>ss.<br>st.<br>su.<br>sv.<br>sw.<br>sx.<br>sy.<br>sz.<br>ta.<br>tb.<br>tc.<br>td.<br>te.<br>tf.<br>tg.<br>th.<br>ti.<br>tj.<br>tk.<br>tl.<br>tm.<br>tn.<br>to.<br>tp.<br>tq.<br>tr.<br>ts.<br>tu.<br>tv.<br>tw.<br>tx.<br>ty.<br>tz.<br>ua.<br>ub.<br>uc.<br>ud.<br>ue.<br>uf.<br>ug.<br>uh.<br>ui.<br>uj.<br>uk.<br>ul.<br>um.<br>un.<br>uo.<br>up.<br>uq.<br>ur.<br>us.<br>ut.<br>uu.<br>uv.<br>uw.<br>ux.<br>uy.<br>uz.<br>va.<br>vb.<br>vc.<br>vd.<br>ve.<br>vf.<br>vg.<br>vh.<br>vi.<br>vj.<br>vk.<br>vl.<br>vm.<br>vn.<br>vo.<br>vp.<br>vq.<br>vr.<br>vs.<br>vt.<br>vu.<br>vv.<br>vw.<br>vx.<br>vy.<br>vz.<br>wa.<br>wb.<br>wc.<br>wd.<br>we.<br>wf.<br>wg.<br>wh.<br>wi.<br>wj.<br>wk.<br>wl.<br>wm.<br>wn.<br>wo.<br>wp.<br>wq.<br>wr.<br>ws.<br>wt.<br>wu.<br>wv.<br>ww.<br>wx.<br>wy.<br>wz.<br>xa.<br>xb.<br>xc.<br>xd.<br>xe.<br>xf.<br>xg.<br>xh.<br>xi.<br>xj.<br>xk.<br>xl.<br>xm.<br>xn.<br>xo.<br>xp.<br>xq.<br>xr.<br>xs.<br>xt.<br>xu.<br>xv.<br>xw.<br>xx.<br>xy.<br>xz.<br>ya.<br>yb.<br>yc.<br>yd.<br>ye.<br>yf.<br>yg.<br>yh.<br>yi.<br>yj.<br>yk.<br>yl.<br>ym.<br>yn.<br>yo.<br>yp.<br>yq.<br>yr.<br>ys.<br>yt.<br>yu.<br>yv.<br>yw.<br>yx.<br>yy.<br>yz.<br>za.<br>zb.<br>zc.<br>zd.<br>ze.<br>zf.<br>zg.<br>zh.<br>zi.<br>zj.<br>zk.<br>zl.<br>zm.<br>zn.<br>zo.<br>zp.<br>zq.<br>zr.<br>zs.<br>zt.<br>zu.<br>zv.<br>zw.<br>zx.<br>zy.<br>zz. |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO     |   |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>G.B.M.C. 6701 NORTH CHARLES ST TOWSON MD21204</b>  |  |  |  |   |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26514

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |                                 |  |   |  |   |  |
|--|--|---------------------------------|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ernest Robey</b>  |  |                                 |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9-18-90</b>  |  | 3. TIME OF DEATH<br><b>5:25</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-16-8456</b>  |  | 5. SEX<br><b>1</b> M <b>2</b> F |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>3-25-27</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Md.</b>   |  |                                 |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Anne Arundel Gen. Hosp.</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Anne Arundel</b>  |  |
| 10a. STATE<br><b>Md.</b>   |  |                                 |  | 10b. COUNTY<br><b>Anne Arundel</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Annapolis</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><b>1</b> YES <b>2</b> NO   |  |                                 |  | 10e. STREET AND NUMBER<br><b>11 Boxwood Rd.</b>   |  | 10f. ZIP CODE<br><b>21403</b>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  |                                 |  | 11. MARITAL STATUS<br><b>1</b> Never Married <b>2</b> <input checked="" type="checkbox"/> Married<br><b>3</b> Widowed <b>4</b> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO<br>IF YES, GIVE WAR OR DATES   |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:   |  |                                 |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4 or 6+)</b>  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Sales</b>  |  |                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Automotive</b>   |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>Earnest W. Robey Sr.</b>  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Alberta B. McClellan</b>   |  |                                 |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Margie Hendrix</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3759 Ridgewood Rd. Davidsonville, Md. 21035</b>   |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  |                                 |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)  |  | 20c. LOCATION — City or Town, State   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |                                 |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Brd. Balto. Md.</b>  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pancytopenia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Leukemia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Gastrointestinal hemorrhage</b>   |  |                                 |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> YES <b>2</b> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  |                                 |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA<br>OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  | 27. MANNER OF DEATH<br><b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide<br><b>5</b> Pending Investigation <b>6</b> Could not be determined   |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |                                 |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><b>1</b> YES <b>2</b> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |                                 |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                 |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Charles W. Kinzer, M.D.</b>   |  | 29c. LICENSE NUMBER<br><b>D5928</b>   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>Sep 18, 1990</b>   |  |                                 |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Charles W. Kinzer, MD, 1833 Forest Drive, Annapolis, MD 21401</b>                         |  | 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>   |  |
| 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |                                 |  | 33. REGISTRAR'S TITLE<br><b>John Davidson-Randall</b>   |  | 34. REGISTRAR'S OFFICE<br><b>John Davidson-Randall</b>  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |   |
|--|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Jeffrey Ransome<br>Jeffery Ranson  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-25-90  |  | 3. TIME OF DEATH<br>1:00PM M  |   |
| 4. SOCIAL SECURITY NUMBER<br>217-76-4879   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>28 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>11/24/61  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Md.  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>5 N. Ellamont  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |   |
| 9c. COUNTY OF DEATH  |  |  |  |  |  |   |   |
| 10a. STATE<br>Md.  |  |  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |   |   |
| 10e. STREET AND NUMBER<br>5 N. Ellamont St.  |  |  |  | 10f. ZIP CODE<br>21229   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black                             |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Edward Ransome  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Beverly Ransome   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Beverly Ransome  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5 N. Ellamont St. Balto. Md. 21229  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Arbutus Memorial Pk.   |  | 20c. LOCATION — City or Town, State<br>Arbutus, Md.  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Cecil A. Estep  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Estep Brothers Funeral Home P.A.<br>1300 Eutaw Pl. Balto. Md. 21217  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hanging<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>INSPECTION |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) scene |  |  |  |   |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input checked="" type="checkbox"/> Homicide 4 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>9-25-90 FOUND  |  | 28b. TIME OF INJURY<br>12:40PM   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED<br>Subject hanged self   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>Basement- House  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>5 N. Ellamont, Baltimore, MD   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Mario F. Golle, Jr.   |  |  |  | 29c. LICENSE NUMBER<br>OCME  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-26-90  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARIO F. GOLLE, JR., MD 111 Penn Street, Baltimore, MD 21201  |  |  |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP-27-1990   |  | 32. REGISTRAR'S SIGNATURE<br>John B. Ransome   |  |  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26516

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GERTRUDE RUDO</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>25</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>12<sup>05</sup> AM</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>214-14-5294</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>03, 21, 1898</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>RUSSIA</b>  |  |  |  | 9a. FACILITY NAME (If not Institution, give street and number)<br><b>Sinai Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |   |
| 9c. COUNTY OF DEATH  |  |  |  | 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>3615 Fords Lane #213</b>  |   |
| 10f. ZIP CODE<br><b>21215</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>HOUSEWIFE</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>AT HOME</b>   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>DAVIS HIGGER</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>TAMARA KOWALSKY</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MRS. RUTH SANDLER</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6803 DIANA CT. BALTIMORE, MD 21209</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ANSHE EMUNAH</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Coronary artery disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Congestive heart failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |   |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Benjamin Morone MD</i>   |  |  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>09/25/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>6601 E Sanzo Rd, Baltimore, MD 21209</b>   |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the report is a general introduction to the subject of the study. It discusses the importance of the problem and the objectives of the research. It also mentions the scope of the study and the methods used.

2. The second part of the report is a detailed description of the experimental work. It includes a description of the apparatus used, the procedure followed, and the results obtained. It also discusses the errors and the limitations of the experiment.

3.



90 26517

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>CARROLL M. Rankin  |  |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 23 YEAR 90  |  | 3. TIME OF DEATH<br>12:30 p M   |  |
| 4. SOCIAL SECURITY NUMBER<br>214-50-0431   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>45 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>2/1/45   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>704 North Lakewood Avenue  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore  |  | 9c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br>MD   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>704 North Lakewood Avenue  |  |  |  | 10f. ZIP CODE<br>21205  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>unknown  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>laborer  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Calvert Dist.   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Francis Rankin   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Bertha C. Brandt   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Patricia Freburger   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>704 N. Lakewood Ave/Balto. MD 21205  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Sacred Heart of Jesus  |  | 20c. LOCATION — City or Town, State<br>Baltimore, MD  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Roland P. Marks, Jr.</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Moran-Ashton Funeral Home, Inc.<br>3000 E. Baltimore St/Balto. MD 21224   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <i>Brain Tumor - Primary, unknown</i><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Metastasis to Bone</i>  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Theodore W. [Signature]</i>  |  |  |  | 29c. LICENSE NUMBER<br>D07517   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/24/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>T. J. WIZNIK MD 429 S Chester St 21231</i>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 27 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randell</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This is to certify that the death certificate is executed with the signature of the attending physician after death. Page 6 may be retained by the hospital or attending physician. Page 6 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FIGURE 4



90 26518

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) <b>ELSIE V. RIDER</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>24</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>8:30 PM</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>219-18-3689</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>67</b> YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>07/21/23</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Good Samaritan Hospital</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH   |   |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>2805 Goodwood Rd.</b>  |  |   |  | 10f. ZIP CODE<br><b>21214</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>12 yrs</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George S. Busick</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elsie K. Evans</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. William J. Rider, SR.</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same as #10</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holy Redeemer</b>  |  | 20c. LOCATION — City or Town, State<br><b>9/28/90 Baltimore, Md.</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Paul L. Hartsock, Jr.</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Baltimore, Md. 21214</b><br><b>Leonard J. Ruck, Inc. 5305 Harford Rd.</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hypotension</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>b. <b>Metabolic encephalopathy</b><br>c. <b>Breast Cancer</b> |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>A. A. Abche</b>   |  |   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/24/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Antoine Abche Good Samaritan Hospital</b>   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendell</b>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26519

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>GEORGE SUMMERS</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>25</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>12:20 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>160-01-3918</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 2, 1902</b>                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>LIBERTY MEDICAL CENTER</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE MD</b>   |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE N/A</b>   |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |   |  |
| 10a. STATE<br><b>Md.</b>  |  | 10b. COUNTY<br><b>N/A</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>312 S. Collins Ave.-Baltimore, Md.</b>   |  |  |  | 10f. ZIP CODE<br><b>21229</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>N/A</b>   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Stationery Engineer</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Kernan Hospital</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Richard Summers</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Blanche ?</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. George W. Phillips</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>319 S. Collins Ave.-Baltimore, Md. 21229</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION <b>9-28-90</b><br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Meadowridge Mem.Pk.Cemetery</b>                                 |  | 20c. LOCATION — City or Town, State<br><b>Howard Co., Md.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>G. Truman Schwab</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>3512 Frederick Avenue<br/>Baltimore, Md. 21229</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASPIRATION PNEUMONIA</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>SEPSIS</b><br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  |  |  |  |  | Approximate Interval Between Onset and Death  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Terance L. Lamb MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D37203</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-25-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>TERANCE LAMB Liberty Medical Center Baltimore Md. 21043</b>   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendella</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>NATHANIEL SWILLING</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>21</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>11:24 P M</b>                                    |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-62-3280</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>37</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7-17-53</b>                   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>BALTO. MD</b>   |  |   |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Lafayette &amp; Chester Streets</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br><b>Maryland</b>  |  |   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                         |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>2033 E LANVALE ST</b>   |  |   |  | 10f. ZIP CODE<br><b>21213</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                           |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Construction</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Worker</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>David Swilling</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Evelyn Parker</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Ernestine Coleman</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2033 E. LANVALE ST. BALTO. MD. 21213</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cem.</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTO. CO. MD.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph L. Russ</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph L. Russ Funeral Home<br/>2222 W. North Ave. BALTO. MD 21216</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Gunshot Wound of Head</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Scene</b>   |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br>3 <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>9-21-90</b>  |  | 28b. TIME OF INJURY<br><b>11:15PM</b>                                   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Subject was shot</b>  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>street</b>   |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>2000 block of E. Lafayette St., Baltimore</b>   |  | 28g. CITY, MD   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Donald Wright</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-22-90</b>                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Donald Wright, M.D., Deputy Chief 111 Penn Street, Baltimore, MD 21201 vl</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendell</b>  |  |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for filing, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

**BALTIMORE, MARYLAND 21203-3146**

DIVISION OF VITAL RECORDS, P.O. BOX 3146,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death of a person be pronounced with \_\_\_\_\_ hours after death. Page 6 may be retained by the hospital or attending physician.

|  |  |  |  |   |  |   |  |  |   |   |  |  |  |
|--|--|--|--|---|--|---|--|--|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JAMES SHULER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>21</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>7:51 am</b>  |  |  |   |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>251-28-4653</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>64</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>8-3-26</b>  |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>S.C.</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TOWSON</b>  |  |   |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |   |   |  |  |  |
| 10a. STATE<br><b>MD</b>  |  |  |  | 10b. COUNTY<br><b>BALTO.</b>  |  |   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTO.</b>   |   |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>1220 Appleleaf Ct.</b>  |  |  |  | 10f. ZIP CODE<br><b>21202</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |   |  |  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>NEGRO</b>   |   |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary <input checked="" type="checkbox"/> (0-12) College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>LABOR</b>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY   |   |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George Shuler</b>  |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rosa Lee Smith</b>                  |  |  |   |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>SABETHA Rawlings</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1304 E. EAGER ST. BALTO. MD</b>   |  |   |  |  |   |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>WESTERN STATE</b>  |  |   |  | 20c. LOCATION — City or Town, State<br><b>BALTO. MD.</b>   |   |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Beth R. Schwartz</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>1220 N. Caroline St</b>  |  |   |  |  |   |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CARDIOPULMONARY ARREST</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |  |  |   | Approximate Interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>END STAGE RENAL DISEASE, CHRONIC OBSTRUCTIVE PULMONARY DISEASE, CARDIOMYOPATHY, SQUAMOUS CELL CARCINOMA OF MOUTH</b>  |  |  |  |   |  |   |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  | 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |   |   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |   |   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                |  |  |   |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |  |   |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Beth R. Schwartz</b>   |  |  |  |   |  | 29c. LICENSE NUMBER<br><b>D38352</b>  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/25/90</b> |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BETH R. SCHWARTZ, M.D. - GBMC: 6701 N. Charles Street, Towson, MD 21204</b>  |  |  |  |   |  |   |  |  |   |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Jane Davidson-Hendell</b>   |  |   |  |  |   |   |  |  |  |





68  
90 265221 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |   |  |   |  |  |
|--|--|--|--|---|---|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>James Leonard SPROW  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>September 25, 1990  |   | 3. TIME OF DEATH<br>9:10P M                        |   |  |  |
| 4. SOCIAL SECURITY NUMBER<br>204-34-3379   |  | 5. SEX<br>XX M 2 F   |  | 6. AGE (In yrs. last birthday)<br>45 YRS.   |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>2-2-1945 |   | 8. BIRTHPLACE (State or Foreign Country)<br>PENNSYLVANIA |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>FRANKLIN SQUARE HOSPITAL   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>ROSSVILLE  |   |  | 9c. COUNTY OF DEATH<br>Baltimore County                             |  |  |
| 10a. STATE<br>MARYLAND   |  |  | 10b. COUNTY<br>BALTIMORE   |   | 10c. CITY, TOWN OR LOCATION<br>EDGEMERE |  |   | 10d. INSIDE CITY LIMITS?<br>1 YES 2 XX NO                |  |
| 10e. STREET AND NUMBER<br>7208 WALDMAN AVENUE  |  |  |  | 10f. ZIP CODE<br>21219  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                             |  |  |
| 11. MARITAL STATUS<br>1 Never Married 2 Married<br>3 Widowed 4 XX Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>XX YES 2 NO<br>IF YES, GIVE WAR OR DATES<br>1960-1965 |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 YES 2 XX NO Specify:       |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12TH GRADE  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>ASSEMBLY WORKER |   |   | 16b. KIND OF BUSINESS/INDUSTRY<br>PRIDE HEALTH     |   |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>HARRY E. SPROW  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ANNA D. DONNELLY   |   |  |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>ANNA DRAVAGE   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7208 WALDMAN AVENUE BALTIMORE, MARYLAND 21219  |   |  |   |  |  |
| 20a. METHOD OF DISPOSITION<br>1 X Burial 2 Cremation 3 Removal from State<br>4 Donation 5 Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>ST. MARY'S CEMETERY 9-29-1990   |   |  | 20c. LOCATION — City or Town, State<br>HANOVER TOWNSHIP, PA         |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>DUDA-RUCK FUNERAL HOME OF DUNDALK, INC.<br>7922 WISE AVENUE DUNDALK MD 21222                                |   |  |   |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung carcinoma<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Pneumonia, metastatic disease |  |  |  |   |   |  |   | Approximate Interval Between Onset and Death             |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 YES 2 XX NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br>1 Inpatient 2 ER/Outpatient 3 DOA<br>OTHER:<br>4 Nursing Home 5 Residence 6 Other (Specify) |   |  |   |  |  |
| 27. MANNER OF DEATH<br>1 X Natural 5 Pending Investigation<br>2 Accident 6 Could not be determined<br>3 Suicide 4 Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |   | 28c. INJURY AT WORK?<br>1 YES 2 NO                 |   | 28d. DESCRIBE HOW INJURY OCCURRED                        |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |  |
| 29a. CERTIFIER (Check only one)<br>1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |   |  |   |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br>N/A  |   | 29d. DATE SIGNED (Month, Day, Year)<br>9/25/90     |   |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Adolph Wychulis, MD 9000 Franklin Square Drive 21237  |  |  |  |   |   |  |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 27 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |   |  |   |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the cause of death be entered on this certificate within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2157

2+6  
90 265231 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |   |  |  |  |                                   |  |
|---|--|---|--|---|--|---|--|---|--|--|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>William T. Smith, Jr.</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09/25/90</b>   |  | 3. TIME OF DEATH<br><b>1740 P.M.</b>                                    |  |   |  |  |  |                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218 48 1301</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>43</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>1-1-47</b>                    |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>   |  |  |  |                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1632 MONTPELIER ST 21218</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  |   |  | 9c. COUNTY OF DEATH   |  |  |  |                                   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO           |  |  |  |                                   |  |
| 10e. STREET AND NUMBER<br><b>1632 MONTPELIER ST.</b>  |  |   |  | 10f. ZIP CODE<br><b>21218</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                             |  |   |  |  |  |                                   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1968</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |  |   |  |  |  |                                   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (1-12) <b>(12)</b> College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>LABOR</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |   |  |  |  |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William T Smith SR</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LOUISE MEADE Smith</b>  |  |   |  |   |  |  |  |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>LOUISE Smith</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1632 MONTPELIER ST BALT MD 21213</b>  |  |   |  |   |  |  |  |                                   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST VA</b>   |  | 20c. LOCATION — City or Town, State<br><b>OWINGS MILLS</b>  |  |   |  |   |  |  |  |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Betta Funeral Home</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>1129 N. CAROLINE ST BALT MD 21213</b>  |  |   |  |   |  |  |  |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>LUNG CANCER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br><b>2 YRS</b> |  |   |  |   |  |   |  |   |  |  |  |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)                                  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b> MD  |  | 29c. LICENSE NUMBER<br><b>038683</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>27 SEP 90</b>                 |  |   |  |  |  |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>LOCH RYAN VA HOSPITAL 3900 LOCH RYAN BLVD BALTIMORE, MD 21218</b>   |  |   |  |   |  |   |  |   |  |  |  |                                   |  |
| 31. DATE FIRED (Month, Day, Year)<br><b>SEP 27 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |   |  |  |  |                                   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26524

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) AKA: Charles Skerman<br>SAMUEL SARUGGIO AKA: Samuel Saruggia   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09 19 90  |  | 3. TIME OF DEATH<br>9:45 A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>212-62-3712A   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>86 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>01-01-1904  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>MD  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>UNION MEMORIAL HOSPITAL   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE City  |  |
| 9c. COUNTY OF DEATH   |  |  |  | 10a. STATE<br>MD  |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 10e. STREET AND NUMBER<br>6116 Belair Rd  |  |  |  | 10f. ZIP CODE<br>21206  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Farm Laborer  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Unknown  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Nettie B. Saruggia   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Margaret Henderson   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6116 Belair Rd. Baltimore Md. 21206  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Zion Cem.  |  | 20c. LOCATION — City or Town, State<br>Balt. Co. Md   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Joseph L. Russ   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Joseph L. Russ Funeral Home, 2222-26 West North Avenue, Baltimore, MD 21216   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTI-LOBAR PNEUMONIA<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death<br>3 WEEKS  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>NONE  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>N/A  |  | 28b. TIME OF INJURY<br>N/A M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>N/A   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>N/A   |  |  |  |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>N/A  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Edwin J. Villamater M.D.   |  |  |  | 29c. LICENSE NUMBER<br>N/A  |  | 29d. DATE SIGNED (Month, Day, Year)<br>09-19-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>EDWIN J. VILLAMATER UNION MEMORIAL HOSPITAL DEPT. OF MEDICINE  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 27 1990  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randell  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for filing, registration, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26525

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |  |   |  |
|---|--|---|---|---|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>BABY GIRL SCARBOROUGH   |  |   |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09 16 1990  |  | 3. TIME OF DEATH<br>7:20 A M   |   |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 8. AGE (In yrs. last birthday)<br>YRS. MONTHS DAYS<br>8 |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>9-8-90 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Md. |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL  |  |   |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  | 9c. COUNTY OF DEATH<br>BALTIMORE CITY  |   |  |
| 10a. STATE  |  | 10b. COUNTY   |   | 10c. CITY, TOWN OR LOCATION   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   |  |
| 10e. STREET AND NUMBER  |  |   |   | 10f. ZIP CODE   |  | 10g. CITIZEN OF WHAT COUNTRY?  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black   |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)                         |   | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>James Owens  |  |   |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Doretha Scarborough  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |   |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in-state rem.   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)  |   | 20c. LOCATION — City or Town, State   |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |   |   | 22. NAME AND ADDRESS OF FACILITY<br>State Anatomy Brd. Balto. Md.   |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Presumed Sepsis<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Prematurity<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |   |   |  | Approximate Interval Between Onset and Death<br>24 hours<br>9 days   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Acute renal failure<br>Intraventricular hemorrhage<br>Hyaline membrane disease  |  |   |   |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |   |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   |  |
| 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |   |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Beth A. Vogt MD  |  |   |   | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/16/90   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Beth A. Vogt MD Johns Hopkins Hospital Baltimore MD 21205  |  |   |   |   |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 27 1990  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |   |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26526

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Maxime H. Seidlitz</i>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>September 22, 1990</i>   |  | 3. TIME OF DEATH<br><i>18:30 P</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>121-03-0969</i>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>85</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>March 28, 1905</i>                             |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Paris, France</i>   |  |   |  | 9. COUNTY OF DEATH<br><i>Montgomery</i>   |  |   |  |
| 10a. STATE<br><i>Maryland</i>  |  |   |  | 10b. COUNTY<br><i>Montgomery</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Silver Spring</i>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><i>2700 Barker Street</i>   |  |   |  |
| 10f. ZIP CODE<br><i>20910</i>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>4 Years</i>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Bookkeeper</i>              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Clerical</i>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Siegried Seidlitz</i>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Regina Springfeder</i>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Stanley A. Seidlitz</i>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>4148 Virginia Street, Fairfax, Virginia 22032</i>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>King David Memorial Garden</i>                                     |  | 20c. LOCATION — City or Town, State<br><i>Falls Church, Virginia</i>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Donald M. Stein</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME<br/>232 CARROLL STREET, N.W., WASHINGTON, D. C.</i>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br>MINUTES<br>YEARS   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>CARDIOPULMONARY ARREST</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <i>ARTERIOSCLEROTIC HEART DISEASE w/ SICK SINUS SYNDROME</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |  |
| c.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>GRAND MAL SEIZURE DISORDER<br/>ORGANIC BRAIN SYNDROME</i>   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Martin C. Sharrel</i>  |
| 29c. LICENSE NUMBER<br><i>D-08944</i>  |  |   |  |   |  |   | 29d. DATE SIGNED (Month, Day, Year)<br><i>9/23/90</i>  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>MARTIN C. SHARREL, M.D.<br/>3720 FARRAGUT AVE.<br/>WASHINGTON, MD 20545</i>  |  |   |  |   |  |   | 31. DATE FILED (Month, Day, Year)<br><i>SEP 27 1990</i>  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.



90 26527

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |   |   |  |
|--|--|---|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MITCHELL SHAFFER</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>26</b> YEAR <b>90</b>   |   | 3. TIME OF DEATH<br><b>2:47A</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>025-05-9344</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS. | 7. DATE OF BIRTH<br>MONTH <b>6</b> DAY <b>16</b> YEAR <b>1916</b>   | 8. BIRTHPLACE (State or Foreign Country)<br><b>BOSTON, MA</b> |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SIMA HOSPITAL</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |   | 9c. COUNTY OF DEATH<br><b>—</b>   |  |
| 10a. STATE<br><b>MASSACHUSETTS</b>   |  | 10b. COUNTY<br><b>BOSTON</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BOSTON</b>  |   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>29 SUTHERLAND RD.</b>   |  |   |  | 10f. ZIP CODE<br><b>02146</b>   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>SALESMAN</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>CURTAINS</b>   |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>BENTZION SHAFFER</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SIMA GOLDA UNKNOWN</b>  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MRS. GERALDINE SHAFFER</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>29 SUTHERLAND RD. BOSTON, MA 02146</b>  |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CHEVRA SHAS</b>  |  | 20c. LOCATION — City or Town, State<br><b>W. ROXBURY, MA</b>  |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CONGESTIVE HEART FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>MESOTHELIOMA (PLEURA)</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |   |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |   |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |   |   |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>E. Nahum MD</b>  |  |   |  | 29c. LICENSE NUMBER   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/26/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><b>ELMER NAHOM ENVA HOSP., BALT., MD</b>   |  |   |  |   |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26528

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARVIN</b><br><i>Howard M. Scheinberg</i>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>9-25-90</i>  |  | 3. TIME OF DEATH<br><i>12:15 PM</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>271-26-4255</i>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>82</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>9-12-08</i>                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Baltimore County General Hospital</i>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Randallstown</i>  |  | 9c. COUNTY OF DEATH<br><i>Baltimore</i>                                    |  |
| 10a. STATE<br><b>MARYLAND</b>   |  |   |  | 10b. COUNTY<br><b>BALTIMORE</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>RANDALLSTOWN</b>                         |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br><i>3718 BRENBROOK DR.</i>   |  |  |  |
| 10f. ZIP CODE<br><i>21133</i>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>WWII- ARMY</i>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b> |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><i>12</i>  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>CLERK</b>   |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>STATE OF MARYLAND</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ABRAHAM SCHEINBERG</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>TILLIE UNKNOWN</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MRS. HENNIE FRIENDLICH</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>8 NORRIS RUN CT. REISTERSTOWN, MD 21136</i>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BETH TFILOH</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Paul D. Lewis</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><i>6010 REISTERSTOWN RD. BALTO., MD 21215</i>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death)</b> → <i>a. Cardiogenic Shock</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |   |  | 29c. LICENSE NUMBER<br><i>D37949</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9-25-90</i>                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Alexander Bogdanovskii MD Baltimore County General Hospital, Randallstown, MD</i>   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 1346,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and filed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26529

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mildred L. STROBEL   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>September 20, 1990  |  | 3. TIME OF DEATH<br>1:15 a.m.  |   |
| 4. SOCIAL SECURITY NUMBER<br>215-16-7902   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>80 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>OCT. 31, 1909                                  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>BALTO. MD.   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>FRANKLIN SQUARE HOSP.  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>ROSEDALE   |  | 9c. COUNTY OF DEATH<br>Baltimore County  |   |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>BALTIMORE   |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE CITY   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>600 LIGHT STREET   |  | 10f. ZIP CODE<br>21201   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American-Indian, Black, White, etc.<br>Specify:<br>WHITE                      |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) —   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>NURSE LPN   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>WINSTON MOOREHEAD   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>LAVINIA WORLEY   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>FAMILY RECORDS   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>SAME AS ABOVE  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>LOUGDON PARK CEM.  |  | 20c. LOCATION — City or Town, State<br>BALTIMORE CITY MD.   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>J. J. J. J. J.  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>EVANGEL CHAPEL OF MEMORIES<br>3800 HARFORD RD. PARKVILLE  |  |  |   |
| 23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Pneumonia<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Cerebrovascular Accident/Myocardial Infarction<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
|  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO     |   |
|  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)             |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Maria-Teresa David, M.D.  |  |  |  | 29c. LICENSE NUMBER<br>N/A  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/20/90   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Maria-Teresa David, M.D. 9000 Franklin Square Dr., Balto., 21231  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 27 1990   |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for statistical, epidemiological, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26530

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Russell W. Spicknall</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9/24/90</b>  |  | 3. TIME OF DEATH<br><b>5:51 P M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>21614 3413</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>4/22/11</b>   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Joseph Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>  |  | 9c. COUNTY OF DEATH<br><b>Balto.</b>  |   |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Balto.</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Balto</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>7601 PERRING TERRACE</b>   |  |  |  | 10f. ZIP CODE<br><b>21234</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>-</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>TOOL MAKER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>MARTIN METALISTIA</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>SAMUEL WILSON SPICKNALL</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MAEFIELD RUSSELL</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>FAMILY RECORDS</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>SAME AS ABOVE</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT. OLIVET CEM.</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTO. CITY, MD.</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Jeffrey L. Gair</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>EVANS CHAPEL OF MEMORIES<br/>8800 HARFORD RD.</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIOPULMONARY FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>ARDS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>SEPSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
|   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)              |   |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Salvatore MD</b>   |  | 29c. LICENSE NUMBER<br><b>1529306</b>   |  | 29d. DATE SIGNED (Month/Day/Year)<br><b>9/24/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>7620 YORK RD TOWSON, MD 21204</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and cemetery filed in the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1875

1875

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

23

24

25

26



ITEM:20b per FH G-668  
10-2-90 cm

90 26531

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |   |  |  |   |  |
|--|--|---|--|---|--|--|---|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>John Joseph STROHMIER  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>September 23, 1990  |  | 3. TIME OF DEATH<br>6:43 p m   |   |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>193-24-7027   |  | 5. SEX<br>XX M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>59 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>9-7-1931                                   |   | 8. BIRTHPLACE (State or Foreign Country)<br>PENNSYLVANIA                                       |  |   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br>FRNAKLIN SQUARE HOSPITAL   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>ROSSVILLE  |  |  | 9c. COUNTY OF DEATH<br>Baltimore County   |  |  |   |  |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>BALTIMORE  |  | 10c. CITY, TOWN OR LOCATION<br>DUNDALK  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |   |  |
| 10e. STREET AND NUMBER<br>3451 LIBERTY PARKWAY   |  |   |  | 10f. ZIP CODE<br>21222  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>KOREA   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                                 |  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>College (1-4 or 5+)<br>1 YEAR   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>DRAFTSMAN  |  |   | 16b. KIND OF BUSINESS/INDUSTRY<br>U.S. COAST GUARD YARD    |  |   |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>PAUL J. STROHMIER   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>KATHRYN ENDLER   |  |  |   |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>LILLIAN W. STROHMIER   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3451 LIBERTY PARKWAY BALTIMORE, MARYLAND 21222   |  |  |   |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>SACRED HEART OF JESUS CEM. 9-27-90  |  |   | 20c. LOCATION — City or Town, State<br>BALTIMORE, MARYLAND |  |   |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>DUDA-RUCK FUNERAL HOME OF DUNDALK, INC.<br>7922 WISE AVENUE DUNDALK, MD 21222   |  |  |   |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Bronchogenic carcinoma<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |  |   | Approximate Interval Between Onset and Death   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>ASCVD<br>Chronic pancreatitis  |  |   |  |   |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Matthew W. MacCumber M.D. Ph.D.  |  |   |  |  |   | 29c. LICENSE NUMBER<br>N/A   |  | 29d. DATE SIGNED (Month, Day, Year)<br>09/23/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Matthew MacCumber, M.D. Ph.D. 9000 Franklin Square Drive, Baltimore 21237   |  |   |  |   |  |  |   |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 27 1990   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |  |   |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the attending physician within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |  |  |  |  |
|--|--|--|--|--|--|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ALICE R. TAYLOR</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> - DAY <b>24</b> - YEAR <b>90</b>  |  |  |  | 3. TIME OF DEATH<br><b>630AM</b>  |  |   |  |  |  |  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-28-2599</b>  |  |  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS. |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10-19-19</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>VA.</b>  |  |  |  |  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Levindale Hebrew Geriatric Center + Hosp. Inc.</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  |  |  | 9c. COUNTY OF DEATH   |  |   |  |  |  |  |  |  |  |
| 10a. STATE<br><b>MD.</b>   |  |  |  | 10b. COUNTY  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>Balto</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |  |  |
| 10e. STREET AND NUMBER<br><b>2434 W. Belvedere Ave</b>   |  |  |  | 10f. ZIP CODE<br><b>21215</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>US.</b>   |  |   |  |  |  |  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>              |  |  |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |  |  |  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Taylor</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Kate Beverly</b>   |  |  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Austin Taylor</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3813 Hayward Ave Balto, Md 21215</b>   |  |  |  |   |  |   |  |  |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Condonation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Garrison Forest Vet</b>   |  |  |  | 20c. LOCATION — City or Town, State<br><b>Wings Mills, Md</b>   |  |   |  |  |  |  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Shela March</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F.H. West 4300 Wabash Ave</b>   |  |  |  |   |  |   |  |  |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CECAL CARCINOMA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |  |  |  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br>3 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M                         |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURED  |  |  |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Carminia O. Hines MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D17037</b>  |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/24/90</b>                                |  |  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ESTHERITA O. Hines MD - LEVINDALE HEBREW GERIATRIC CENTER - Hospital</b>   |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |  |  | BALTIMORE   |  |   |  |  |  |  |  |  |  |

1000  
1000  
1000

1000  
1000  
1000

1000

1000

1000

1000

1000

90 26533

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>John L. Trent</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>09</i> DAY <i>25</i> YEAR <i>90</i>  |  | 3. TIME OF DEATH<br><i>0934 A M</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>223 24 4976</i>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (in yrs. last birthday)<br><i>66</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>05/27/24</i>  |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><i>Lock Raven VAMC</i>  |  |  |  | 9. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore</i>  |  | 10. COUNTY OF DEATH  |  |
| 11. RESIDENCE OF DECEDENT  |  |  |  | 12. STATE<br><i>MD</i>  |  | 13. COUNTY<br><i>Baltimore</i>   |  |
| 14. STREET AND NUMBER<br><i>2134 Mt Holly Street</i>   |  |  |  | 15. ZIP CODE<br><i>21216</i>  |  | 16. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |
| 17. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 18. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 20. RACE — American Indian, Black, White, etc.<br>Specify: <i>Black</i>  |  |
| 21. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 22. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Bricklayer</i>  |  | 23. KIND OF BUSINESS/INDUSTRY<br><i>Construction</i>  |  |  |  |
| 24. FATHER'S NAME (First, Middle, Last)<br><i>William Trent</i>  |  |  |  | 25. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Sally Ayers</i>   |  |  |  |
| 26. INFORMANT'S NAME (Type/Print)<br><i>Thelma Trent</i>   |  |  |  | 27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2134 Mt. Holy St. Balto. Md. 21216</i>   |  |  |  |
| 28. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 29. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Woodlawn Cemetery</i>  |  | 30. LOCATION — City or Town, State<br><i>Balto. Md.</i>   |  |  |  |
| 31. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>William M. Wainwright</i>  |  |  |  | 32. NAME AND ADDRESS OF FACILITY<br><i>Wainwright Funeral Home<br/>2700 Edmondson Ave. Balto. Md. 21223</i>   |  |  |  |
| 23. PART 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><i>(R) Lung Collapse</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>Squamous cell cancer Lung</i><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Coronary artery disease, Congestive heart failure</i>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  | 28. DATE OF INJURY (Month, Day, Year)  |  |
|  |  | 29. TIME OF INJURY<br>H M  |  | 30. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 31. DESCRIBE HOW INJURY OCCURRED   |  |
|  |  | 32. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 33. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>David Tasker MD</i>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9-25-90</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>DAVID TASKER MD L.R.V.A.M.C. Baltimore MD</i>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>SEP 27 1990</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Hendall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 3146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26534

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>TOLLEY, JUANITA FAY TOLLEY   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9 23 90   |  | 3. TIME OF DEATH<br>3:45A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>289-28-8674   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>57 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>JUNE 5, 1933  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>KENTUCKY   |  |  |  | 9. COUNTY OF DEATH  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>CHURCH HOSPITAL  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY   |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>BALTIMORE   |  | 10c. CITY, TOWN OR LOCATION<br>DUNDALK  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>7808 KAVANAGH ROAD   |  |  |  | 10f. ZIP CODE<br>21222  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8TH GRADE   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>CARTON MAKER  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>OWENS PLASTIC COMPANY   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>ELMER SECTON  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>VIRGIE PARKER  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>DARRELL TOLLEY   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7808 KAVANAGH ROAD BALTIMORE, MARYLAND 21222   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>HOLLY HILL MEMORIAL 9-26-1990  |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MARYLAND  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Scott P. Gordon   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>DUDA-RUCK FUNERAL HOME OF DUNDALK, INC.<br>7922 WISE AVENUE DUNDALK, MD 21222   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC LUNG CANCER<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>LIVER METASTASES LIVER METASTASES<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO               |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Terance L. Lamb M.D. Hospital Physician   |  |  |  | 29c. LICENSE NUMBER<br>D37203   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-23-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>TERANCE L. LAMB CHURCH HOSPITAL 100 N. BROADWAY, Balt. MD   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 27 1990   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



10  
90 265351. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |   |  |   |  |                     |  |  |  |
|--|--|---|--|---|--|--|--|---|--|---|--|---------------------|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MARY E. TELAKOWICZ   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9 22 90   |  | 3. TIME OF DEATH<br>825 P M  |  |   |  |   |  |                     |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>213-18-3268   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>69 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>8-30-1921                                     |  | 8. BIRTHPLACE (State or Foreign Country)<br>N. CAROLINA   |  |   |  |                     |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>MERCY HOSPITAL   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY   |  |  |  | 9c. COUNTY OF DEATH   |  |   |  |                     |  |  |  |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>BALTIMORE  |  | 10c. CITY, TOWN OR LOCATION<br>ESSEX  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |                     |  |  |  |
| 10e. STREET AND NUMBER<br>813 ARNCLIFFE ROAD   |  |   |  | 10f. ZIP CODE<br>21221  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  |   |  |                     |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                     |  |   |  |   |  |                     |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9TH GRADE<br>College (1-4 or 5+) N/A   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>HOUSEKEEPING                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br>MARYLAND NATIONAL BANK  |  |  |  |   |  |   |  |                     |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>CHESTER SALGEE  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MARY NANCY NOT KNOWN   |  |  |  |   |  |   |  |                     |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>STANLEY J. TELAKOWICZ, JR.   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7014 EASTERN AVENUE BALTIMORE, MARYLAND 21224  |  |  |  |   |  |   |  |                     |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>CREST LAWN MEMORIAL 9-26-1990   |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MARYLAND  |  |  |  |   |  |   |  |                     |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Scott P. Cooney</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>DUDA-RUCK FUNERAL HOME OF DUNDALK, INC.<br>7922 WISE AVENUE DUNDALK, MD 21222   |  |  |  |   |  |   |  |                     |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. End stage metastatic bronchogenic lung ca<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |                     |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO      |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |                     |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                           |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                            |  |  |  |   |  |   |  |                     |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |                     |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |                     |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. J. Mummert</i> MD  |  | 29c. LICENSE NUMBER |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/22/90 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>T. M. MUMMERT 301 St. Paul Place Balt. Md. 21204  |  |   |  |   |  |  |  |   |  |   |  |                     |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 27 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |  |   |  |   |  |                     |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br>ADA MAE WILLIAMS  |  |   |  | 2. DATE OF DEATH<br>MONTH 9 DAY 22 YEAR 90  |  | 3. TIME OF DEATH<br>1:55 A M  |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>28 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>4-20-62  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>University Hospital   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br>MD.   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br>BALTO.   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>1826 N. Collington Ave  |  |   |  | 10f. ZIP CODE<br>21213  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Negro                             |  |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Labor   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Feaster Williams   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Annie Pearl  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Annie Williams  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1826 N. Collington Ave BALTO. MD 21213   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>BALTO. Cem.   |  | 20c. LOCATION — City or Town, State<br>BALTO. MD.   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Betts Funeral Home   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>1129 N. Caroline St   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gunshot Wound of Chest<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide<br>4 <input checked="" type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)<br>9-22-90   |  | 28b. TIME OF INJURY<br>1:20 A M   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>Subject was shot   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>street  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>2100 block of E. Lafayette Ave., Baltimore  |  | 29. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |
| 29a. SIGNATURE AND TITLE OF CERTIFIER<br>Donald G. Wright   |  |   |  | 29b. LICENSE NUMBER<br>OCME   |  | 29c. DATE SIGNED (Month, Day, Year)<br>9-23-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Donald G. Wright, M.D., Deputy Chief 111 Penn Street, Baltimore, MD 21201 vl   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 27 1990  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendell   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26537

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |   |
|---|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WALTER WILDBERGER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>16</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>6 34 A M</b>                                     |   |
| 4. SOCIAL SECURITY NUMBER<br><b>213100312</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>6 19 14</b>                   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>BON SECOURS HOS.</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>  |  | 9c. COUNTY OF DEATH   |   |
| 10a. STATE<br><b>MD</b>   |  |  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                         |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |   |   |
| 10e. STREET AND NUMBER<br><b>1217 W FAYETTE ST</b>  |  |  |  | 10f. ZIP CODE<br><b>21223</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                          |   |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Laborer</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frederick Moore Wildberger</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Beatrice Laura Marble</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Frederick Wildberger</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>809 N. Woodlynn Rd. Balto. Md. 21221</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>in-state rem.</b>  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | 20c. LOCATION — City or Town, State  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Tommy A. [Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board Balto. Md.</b>  |  |   |   |
| 23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>a. <b>Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>ASCVD E Hypertension</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Upper GI Bleeding</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>Arthritis of Left Hip</b> |  |  |  |  |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)                                  |   |
| 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Ali I. BAYKALER, MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D02031</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-19-90</b>                   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><b>Ali I. BAYKALER, MD. 831 Poplar Grove St. Balto. Md. 21216</b>   |  |  |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26538

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>John J. Welsh, Jr.</b>  |  |  |  |  |   | 2. DATE OF DEATH<br>MONTH <b>Sep</b> DAY <b>26</b> YEAR <b>1990</b>              |  | 3. TIME OF DEATH<br><b>1:30 P</b> M  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-94-3391</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>25 YRS.</b>   |   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>08/06/65</b>                           |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>North Carol</b>   |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>                                |  |   |  |
| 10a. STATE<br><b>Md</b>  |  |  |  | 10b. COUNTY<br><b>Baltimore</b>  |   | 10c. CITY, TOWN OR LOCATION<br><b>Arbutus</b>                                    |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>1113 Elmridge Avenue</b>  |  |  |  | 10f. ZIP CODE<br><b>21229</b>  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                            |  |   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify <b>White</b> |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>nurse</b>   |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>health</b>                        |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John J. Welsh, Sr.</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Jo Brocato</b>  |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John J. Welsh, Sr.</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1042 Grove Hill Road Arbutus Md 21227</b>  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>  |  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b> |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ambrose Funeral Home<br/>1328 Sulphur Spring Road, Arbutus, Md</b>  |   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. metastatic anaplastic astrocytoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d.</b> |  |  |  |  |   |  |  | Approximate Interval Between Onset and Death   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Status epilepticus</b>  |  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |   |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO  |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>D30185</b>   |   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/26/90</b>                  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Paul Miller MD 405 Frederick Rd. Suite 152 Catonsville, Md. 21228</b>  |  |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>  |  |  |  | REGISTRAR'S SIGNATURE<br>  |   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires the funeral certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6.6

90 26539

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Rosetha Watkins</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 22 90</b>   |  | 3. TIME OF DEATH<br><b>7:35</b> M   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>218-03-4959</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8-30-06</b>   |   |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Reswick</b>  |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balt.</b>   |  | 8c. COUNTY OF DEATH<br><b>Balt. City</b>  |   |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |   |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>400 E. 25th Street</b>   |  |  |  | 10f. ZIP CODE<br><b>21218</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                             |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Nursing Assistant</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Nursing Home</b>   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Ferdinand Pinkett</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lottie Stephens</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Margaret Johnson</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1538 Stonewood Rd., Baltimore, MD. 21239</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arbutus Mem. Park</b>   |  | 20c. LOCATION — City or Town, State<br><b>Arbutus, MD</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Charlene D. Braun</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph H. Brown F.H. P.O. Box 4433<br/>Baltimore, MD. 21223</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CVA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes<br/>ASCVD</b>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Robert M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D34988</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/22/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>David G. Roberts M.D. 6565 N. Charter St. Balto. 21204</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26540

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Annie Young</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>9</i> DAY <i>21</i> YEAR <i>90</i>   |  | 3. TIME OF DEATH<br><i>7:27</i>  |   |
| 4. SOCIAL SECURITY NUMBER<br><i>220-30-4750</i>   |  | 5. SEX<br><i>1</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>101</i> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>May 8 1889</i>   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Libert Medical Center</i>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore</i>   |  | 9c. COUNTY OF DEATH  |   |
| 10a. STATE<br><i>Maryland</i>   |  |  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><i>Baltimore</i>  |   |
| 10d. INSIDE CITY LIMITS?<br><i>1</i> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><i>1701 Eutaw Street</i>  |  | 10f. ZIP CODE<br><i>21217</i>  |   |
| 10g. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>  |  |  |  | 11. MARITAL STATUS<br><i>3</i> <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced                                    |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>Black</i>  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |   |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Housekeeper</i>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Domestic</i>   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Charles Fenwick</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Victoria Jordan</i>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Victoria Brown</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>4122 Mountwood Road Baltimore, MD 21229</i> |  |  |   |
| 20a. METHOD OF DISPOSITION<br><i>1</i> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><i>4</i> <input type="checkbox"/> Donation <i>6</i> <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>New Cathedral Cemetery</i>   |  | 20c. LOCATION — City or Town, State<br><i>Baltimore, MD</i>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Vernon R Bailey</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Nutter Funeral Homes,<br/>2501 Gwynns Falls Parkway<br/>Baltimore, Maryland 21216</i>                    |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sepsis</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>Pyelonephritis</i><br><i>Urinary tract infection</i> |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>cerebrovascular accident</i>   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <i>1</i> <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <i>4</i> <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br><i>1</i> <input checked="" type="checkbox"/> Natural <i>5</i> <input type="checkbox"/> Pending Investigation<br><i>2</i> <input type="checkbox"/> Accident <i>6</i> <input type="checkbox"/> Could not be determined<br><i>3</i> <input type="checkbox"/> Suicide <i>4</i> <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO  |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br><i>1</i> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><i>2</i> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Levold Apollon MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>D37874</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9/21/90</i>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Liberty Medical Center</i>  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><i>SEP 27 1990</i>   |  |  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be prepared within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or traumatic event, the medical examiner must be notified at once.



90 26541

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ruth Celeste Yeatman</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 22 1990</b>  |  | 3. TIME OF DEATH<br><b>10:30 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-20-8351</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Nov. 24 1901</b>                                   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Meridian Nursing Center</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH<br><b>-</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>-</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>6040 Harford Road</b>   |  |  |  | 10f. ZIP CODE<br><b>21214</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>-</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Accountant</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Dept. of Army</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Bishop Yeatman</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Matilda Mitchell</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Linda G. Enright</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7954 Arden Ct., Dunn Loring, Va. 22027</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Woodlawn, Md.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Bryan W. Clary</i><br><b>Bryan W. Clary</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lemmon-Mitchell-Wiedefeld<br/>Timonium, Maryland 21093</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>1. AS H/O Sudden Aortic dissection</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>2. Coronary artery disease + AF + Hypertension</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>3. Cerebral aneurysm &amp; Rupture</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Frederick W. Anderson MD</i><br><b>Frederick W. Anderson MD</b>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/23/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DONALD W. MINTZER 3009 EVERGREEN AVE BALTIMORE</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Johanna Davidson-Randall</i><br><b>Johanna Davidson-Randall</b>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) AKA: Anna E. Zahm<br>Anne E. Zahn  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-24-90   |  | 3. TIME OF DEATH<br>M<br>2:56PM   |  |
| 4. SOCIAL SECURITY NUMBER<br>215-24-0172  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>63 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>01/27/27  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>North Arundel Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Glen Burnie  |  | 9c. COUNTY OF DEATH<br>Anne Arundel County  |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Anne Arundel  |  | 10c. CITY, TOWN OR LOCATION<br>Glen Burnie  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>120 Faywood Avenue  |  |  |  | 10f. ZIP CODE<br>21061  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>10   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Bookkeeper                      |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Insurance   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>James Vernay   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Elsie Flock  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Albert J. Zahm  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2609 Wilkens Avenue, Baltimore, Maryland 21223   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Baltimore-Washington Crematory   |  | 20c. LOCATION — City or Town, State<br>Laurel, Maryland   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Ambrose Funeral Home, Inc.<br>1328 Sulphur Spring Road, Arbutus, Md. 21227  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple injuries<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>XXX YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>XXX YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>XXX YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br>9-24-90  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>Road   |  | 28e. DESCRIBE HOW INJURY OCCURRED<br>Driver in auto/tractor trailer impact  |  |   |  |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>Ritchie Hwy. & Mountain Rd.<br>Anne Arundel County, MD           |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |
| 29c. LICENSE NUMBER<br>OCME   |  |  |  |   |  |   | 29d. DATE SIGNED (Month, Day, Year)<br>9-25-90   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>FRANK PERETTI, MD 111 Penn Street, Baltimore, MD 21201   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 27 1990  |  |  |  |   |  |   | 32. REGISTRAR'S SIGNATURE<br>  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

P.O. BOX 15146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3, 4, and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 26543

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |                          |   |   |
|--|--|--|--|--|--------------------------|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Addison, Joseph Theodore</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>9</i> DAY <i>25</i> YEAR <i>90</i>  |                          | 3. TIME OF DEATH<br><i>7:00 AM</i>  |   |
| 4. SOCIAL SECURITY NUMBER<br><i>216-073982</i>   |  | 5. SEX<br><i>M</i>   | 6. AGE (In yrs. last birthday)<br><i>82</i> YRS. | IF UNDER 1 YEAR<br>MONTHS  | IF UNDER 24 HRS.<br>DAYS | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>9/30/07</i>  | 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i> |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Baltimore DVA Loch Raven</i>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore</i>  |                          | 9c. COUNTY OF DEATH<br><i>N/A</i>   |   |
| RESIDENCE OF DECEDENT  |  |  |  |  |                          |   |   |
| 10a. STATE<br><i>MD</i>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><i>Balto</i>  |                          | 10d. INSIDE CITY LIMITS?<br><i>1</i> YES <i>2</i> NO  |   |
| 10e. STREET AND NUMBER<br><i>5802A Edgemark Rd.</i>  |  |  |  | 10f. ZIP CODE<br><i>21239</i>  |                          | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   |
| 11. MARITAL STATUS<br><i>1</i> Never Married <i>2</i> Married<br><i>3</i> Widowed <i>4</i> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><i>1</i> YES <i>2</i> NO<br>IF YES, GIVE WAR OR DATES<br><i>WW II</i>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><i>1</i> YES <i>2</i> NO Specify: |                          | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                                 |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>4</i> College (1-4 or 5+) <i>4</i>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Clerk</i><br><i>XXXXXXXXXXXXXX</i>             |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Federal Government</i>  |                          |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Harry K. Addison</i><br><i>XXXXXXXXXXXXXX</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Mabel Estelle Kraft</i><br><i>XXXXXXXXXXXXXX</i>   |                          |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Grace Bachelor</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>7911 Highpoint Rd., Baltimore, MD 21234</i>      |                          |   |   |
| 20a. METHOD OF DISPOSITION<br><i>1</i> Burial <i>2</i> Cremation <i>3</i> Removal from State<br><i>4</i> Donation <i>6</i> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Lorraine Park Cemetery</i>  |  | 20c. LOCATION — City or Town, State<br><i>Woodlawn, MD</i>   |                          |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>R. George Allen</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>ROBERT C. ALTENBURG FUNERAL HOME, INC.</i><br><i>6009 Harford Rd., Baltimore, MD 21214</i>                    |                          |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <i>Respiratory failure 20 to asphyxiation</i><br>b. <i>secondary to asphyxiation</i><br>c. <i>secondary to infection</i><br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |                          | Approximate Interval Between Onset and Death  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |                          | 24a. WAS AN AUTOPSY PERFORMED?<br><i>1</i> YES <i>2</i> NO  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><i>1</i> YES <i>2</i> NO   |  |  |  |  |                          | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><i>1</i> YES <i>2</i> NO |   |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <i>1</i> Inpatient <i>2</i> ER/Outpatient <i>3</i> DOA<br>OTHER: <i>4</i> Nursing Home <i>5</i> Residence <i>6</i> Other (Specify)  |  | 27. MANNER OF DEATH<br><i>1</i> Natural <i>5</i> Pending investigation<br><i>2</i> Accident <i>6</i> Could not be determined<br><i>3</i> Suicide <i>4</i> Homicide |  |  |                          |   |   |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br><i>1</i> YES <i>2</i> NO   |                          | 28d. DESCRIBE HOW INJURY OCCURRED   |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |                          |   |   |
| 29a. CERTIFIER (Check only one)<br><i>1</i> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><i>2</i> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |                          |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J.C. Brackett MD MR0403</i>  |  |  |  | 29c. LICENSE NUMBER  |                          | 29d. DATE SIGNED (Month, Day, Year)<br><i>9/25/90</i>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>J.C. Brackett</i>  |  |  |  |  |                          |   |   |
| 31. DATE FILED (Month, Day, Year)<br><i>SEP 28 1990</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |                          |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26544

|  |  |   |   |   |  |   |   |   |  |  |  |   |  |   |  |
|--|--|---|---|---|--|---|---|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Robert L. Airey</b>   |  |   |   | 2. DATE OF DEATH<br>MONTH: <b>Sept.</b> DAY: <b>26</b> , YEAR: <b>1990</b>  |  | 3. TIME OF DEATH<br><b>1957</b> M   |   |   |  |  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-01-5380</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>2-19-1917</b>  |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Loch Raven V. A. Hospital</b>   |  |   |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  |   | 9c. COUNTY OF DEATH<br><b>-----</b>   |   |  |  |  |   |  |   |  |
| RESIDENCE OF DECEDENT  |  |   |   |   |  |   |   |   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Harford</b>   |   | 10c. CITY, TOWN OR LOCATION<br><b>Belair</b>  |  |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |  |  |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>1357 Crofton Dr.</b>  |  |   |   | 10f. ZIP CODE<br><b>21014</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |   |  |  |  |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b>   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>-----</b>  |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |   |  |  |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+) <b>-----</b>  |  |   | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Machinist</b> |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Machine Parts</b>  |   |   |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Harry Airey</b>  |  |   |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Amy -----</b>   |  |   |   |   |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Gloria F. Petrucci</b>   |  |   |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1357 Crofton Dr. Belair, Md. 21014</b>  |  |   |   |   |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>-----</b>   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>  |   |   | 20c. LOCATION — City or Town, State<br><b>Balto... Md.</b> |   |   |   |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Hartley Miller</i>   |  |   |   | 22. NAME AND ADDRESS OF FACILITY<br><b>Hartley Miller Funeral Home<br/>7527 Harford Rd. Balto., Md. 21234</b>   |  |   |   |   |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>metastatic small cell lung cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |   |   |  |   |   | Approximate Interval Between Onset and Death  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>-----  |  |   |   |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>-----</b> |   | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>-----</b>  |   | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE NOW INJURY OCCURRED<br><b>-----</b> |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Wanda J. Kowalski</i><br><b>KACIN MS DOBGE MD</b>   |   |   |  |   |   |   |  |  |  | 29c. LICENSE NUMBER<br><b>-----</b>               |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/26/90</b> |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>KACIN MS DOBGE MD</b>  |  |   |   |   |  |   |   |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>  |  |   |   | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |   |   |  |  |  |   |  |   |  |



90 26545

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>GEORGE SHANNON BOWERMAN, SR.   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>SEPT. 26, 1990  |  | 3. TIME OF DEATH<br>4:51 p.m.   |   |
| 4. SOCIAL SECURITY NUMBER<br>217-03-0609   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 8. AGE (In yrs. last birthday)<br>84 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>MAR. 10, 1906   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>FRANKLIN SQUARE HOSPITAL   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  |   |  | 9c. COUNTY OF DEATH<br>BALTIMORE  |   |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |   |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>BALTIMORE  |  | 10c. CITY, TOWN OR LOCATION<br>WHITE MARSH  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>11002 BOWERMAN ROAD  |  |   |  | 10f. ZIP CODE<br>21162  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                                    |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) N/A<br>College (1-4 or 5+) N/A   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>MECHANIC   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>POLICE DEPARTMENT   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>HENRY HAMMOND   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>JANE SHANNON   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>MINNIE M. BOWERMAN (WIFE)  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11002 BOWERMAN RD, WHITE MARSH, MD. 21162  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>METRO CREMATORY   |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MARYLAND  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Chas. A. Schimunek</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>SCHIMUNEK FUNERAL HOME, INC.<br>9705 BELAIR ROAD, BALTIMORE, MD. 21236  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>C2 lung (right)</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>CVA Oct. 1989</i>   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO               |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>William A. Tyson M.D.</i>  |  |   |  | 29c. LICENSE NUMBER<br>D11752   |  | 29d. DATE SIGNED (Month, Day, Year)<br>Sept. 27, 1990   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DR. WILLIAM A. TYSON, M.D., BRADSHAW & SILVER SPRUCE RDS, KINGSVILLE, MD. 21087   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Jane Davidson-Randall</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





ITEMS: 1, 17, 19a per FH  
G-668 10-2-90 cm

90 26546

1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ashley E (Burley) Burkley</b>  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>26</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>1:33 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-25-3087</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>1</b> YRS.   |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>4-16-89</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>UNIVERSITY</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE, MD.</b>  |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>941 N. MOUNT STREET</b>  |  | 10f. ZIP CODE<br><b>21217</b>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>CHILD</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>CHILD</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ANTHONY BURKLEY BURLEY</b>  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>PATRICIA HERRINGTON</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ANTHONY BURKLEY BURLEY</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7068 DUCKETT LN.-ELKRIDGE, MD. 21227</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>KING MEMORIAL PARK</b>   |  | 20c. LOCATION — City or Town, State<br><b>RANDALLSTOWN, MD</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardiopulmonary arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. Liver Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Ascites</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. Biliary Atresia</b> |  |   |  |   | Approximate Interval Between Onset and Death<br><b>189</b><br><b>Summer</b><br><b>Summer 189</b><br><b>Birth</b>                                   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Esophageal Varices</b><br><b>Malabsorption - Totally dependent on TPN for nutrition</b>  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  |
| 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Doris M. Moutos MD</b>  |  | 29c. LICENSE NUMBER<br><b>D40244</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-26-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Doris Moutos MD University of Maryland Medical System</b>   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the funeral permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JAMES WILLIAM BURRISS</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>22</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>1:30 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-24-4317</b>  |  | 5. SEX<br><b>1 M 2 F</b>   |  | 6. AGE (In yrs. last birthday)<br><b>58</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 31, 1931</b>                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>21001 Georgia Avenue</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Brookville</b>  |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>   |  | 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>  |  |
| 10e. STREET AND NUMBER<br><b>920 Rosemare Street</b>   |  |  |  | 10f. ZIP CODE<br><b>20904</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><b>1 NEVER MARRIED 2 MARRIED 3 WIDOWED 4 DIVORCED</b>  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><b>1 YES 2 NO</b><br>IF YES, GIVE WAR OR DATES<br><b>1961</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 NO</b> Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                          |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 11</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Truck Driver</b>                    |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Trucking</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Elick E. Burriss</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marthalene - Unknown</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Betty Jean Burriss</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same as 10e.</b>                          |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 BURIAL 2 CREMATION 3 REMOVAL FROM STATE 4 DONATION 5 OTHER (Specify)</b>  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Colesville Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Colesville, Maryland</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Muriel H. Barber</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Muriel H. Barber Funeral Home<br/>P. O. Box 5038, Laytonsville, Md. 20882</b>                          |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Contact Gunshot Wound of Head</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 NO</b>  |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b> |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 NO</b>  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 OOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |   |  |  |  |
| 27. MANNER OF DEATH<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>9-22-90</b>   |  | 28b. TIME OF INJURY<br><b>12-1 P M</b>  |  | 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURED<br><b>Subject shot self</b>   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>21001 Georgia Ave., Brookville, Montgomery Co.,</b>        |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MD</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Mario F. Golle</i>   |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-23-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Mario F. Golle, Jr., M.D., Assistant 111 Penn Street, Baltimore, MD 21201 vl</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial or interment permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26548

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Walter Brown</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>21</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>8:44 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>415-01-0242X</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9 11 08</b>   |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>LIBERTY MEDICAL CENTER</b>  |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 8c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>WOODLAWN</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>9A GREENBURY CT</b>   |  |  |  | 10f. ZIP CODE<br><b>21207</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>MAINTENANCE MAN</b>         |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Priest)<br><b>Jessie Hunter</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9A GREENBURY CT Baltimore, MD 21207</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>WESTERN STAR GEN. CATONSVILLE, MD</b>                           |  | 20c. LOCATION — City or Town, State<br><b>CATONSVILLE, MD</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Henry Harris</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>CHARTMAN-HARRIS FH. 1701 McCulloh St Baltimore, MD 21217</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |   |  |   |  |
| a. <b>Overwhelming Sepsis</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| b. <b>Severe Hypotension</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| c. <b>Malignant Ventricular Arrhythmias</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| d. <b>Respiratory Failure</b>  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Keren Elder MD House Officer</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D38993</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/21/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Keren Elder MD 3001 South Hanover ST BALT MD.</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 20 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Mandell</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

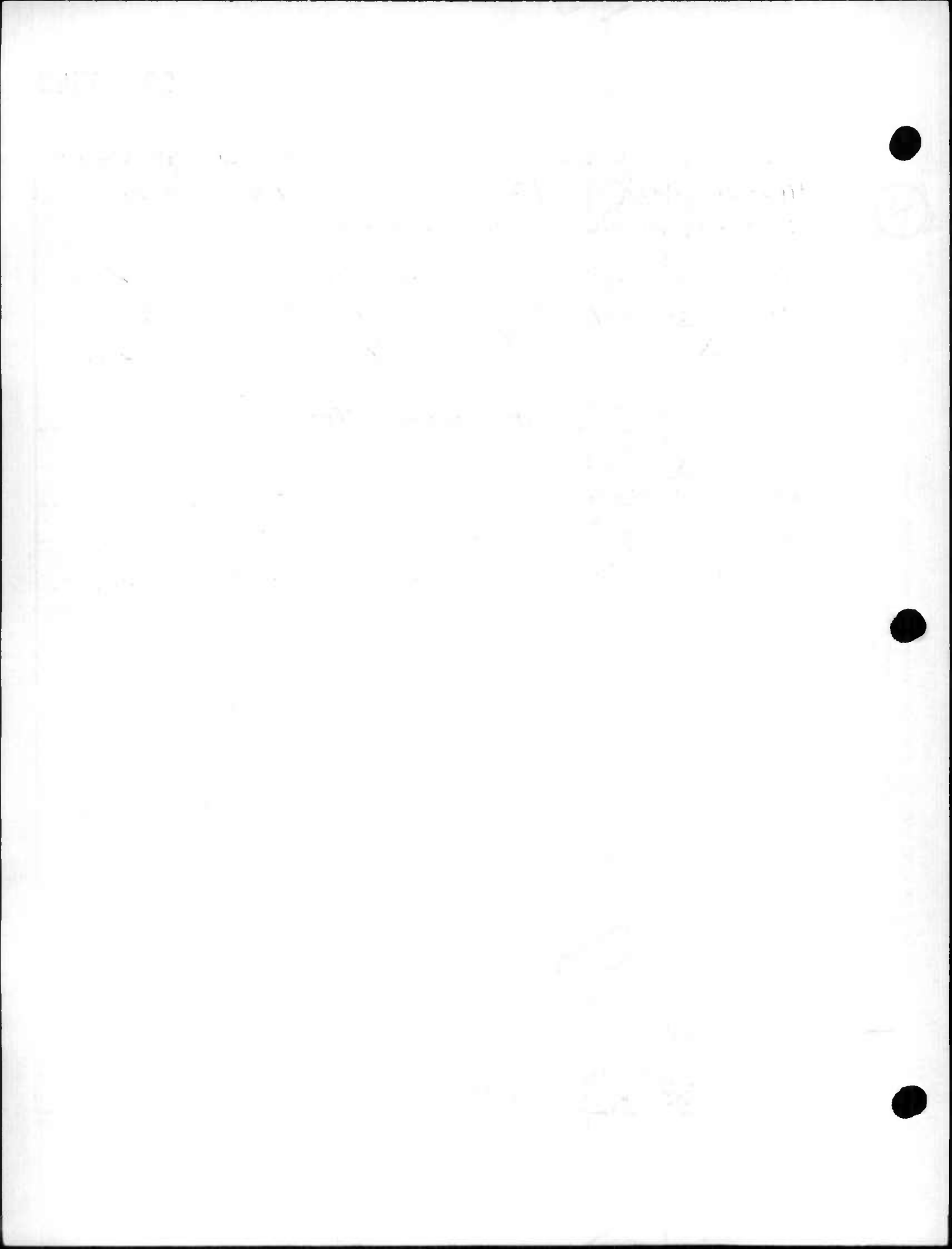
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26549

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Charles A. Bregel</u>   |  |   |  | 2. DATE OF DEATH<br>MONTH <u>9</u> DAY <u>25</u> YEAR <u>90</u>   |  | 3. TIME OF DEATH<br><u>17:30 p.m.</u>  |  |
| 4. SOCIAL SECURITY NUMBER<br><u>215-07-1346</u>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><u>79</u> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><u>05-28-11</u>                               |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><u>St. Agnes Hosp.</u>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Baltimore</u>   |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><u>Md.</u>   |  |   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><u>Baltimore</u>                                      |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><u>7102 Lounsbury Ct.</u>  |  |   |  | 10f. ZIP CODE<br><u>21207</u>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                                       |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>White</u>              |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Salesman</u>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Paper Products</u>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Charles W. Bregel</u>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Lola German</u>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Pauline A. Bregel</u>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>7102 Lounsbury Ct. Balto. Md. 21207</u>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)  |  | 20c. LOCATION — City or Town, State   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>[Signature]</u>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><u>State Anatomy Board Balto. Md.</u>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Aspiration Pneumonia</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. <u>Extensive metastatic bone disease of unknown Primary Etiology</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br><u>15 days</u><br><u>more than 27 days</u> |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Terease E. Kwiatkowski MD</u>  |  |   |  | 29c. LICENSE NUMBER<br><u>AS2438528-760</u>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>9/25/90</u>                                |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Terease E Kwiatkowski, MD</u>  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><u>SEP 28 1990</u>  |  | 32. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26550

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Eva Mae Bailey</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09-27-90</b>  |  | 3. TIME OF DEATH<br><b>12:10A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>164-01-7552</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>04-04-16</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Stella Maris Hospice</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |   |  | 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>BALTO.</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>522 Elmwood Rd.</b>  |  |   |  | 10d. ZIP CODE<br><b>21206</b>  |  | 10e. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b><br>College (1-4 or 5+) <b>College</b>    |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Seamstress</b>   |  |
| 16b. KIND OF BUSINESS/INDUSTRY<br><b>Western Coat &amp; Pad</b>  |  |   |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>John Wenrick</b>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Stella Brown</b>  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William A. Bailey</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>522 Elmwood Rd. Balto., Md. 21206</b>        |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parkwood Cem.</b>   |  | 20c. LOCATION — City or Town, State<br><b>Balto., Md.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>John C. Miller Inc.<br/>6415 Belair Rd. Balto., Md. 21206</b>   |  |   |  |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |   | Approximate Interval Between Onset and Death   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Glioma</b>  |  |   |  |  |  |   |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. DESCRIBE HOW INJURY OCCURRED   |  |
| 28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Carla S. Alexander</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D 27087</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>09-27-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Carla S. Alexander, M.D. - Stella Maris Hospice-Dulaney Valley Rd.-Towson 21204</b>  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>  |  |   |  | REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

CHY. 11

MARY Bichy

90 26551

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. **IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mary F. Bichy  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-26-90   |  | 3. TIME OF DEATH<br>M  |  |
| 4. SOCIAL SECURITY NUMBER<br>215-10-3145   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>94 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>12-31-1895                                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Kentucky   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Seton Manor Nursing Home  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore                                     |  |
| 9c. COUNTY OF DEATH  |  |  |  |   |  |  |  |
| 10a. STATE<br>MD.  |  |  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br>501 West Franklin Street  |  |  |  |
| 10f. ZIP CODE<br>21201   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6th Grade<br>College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Saleslady   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Read's Drug Store                                  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Henry Clay Mills  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Unknown  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Harry E. Bichy   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5 Talister Court Baltimore, Md.-21237  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Greenmount Crematory   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Md.   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>James M. Murphy   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>John C. Miller, Inc. 6415 Belair Road<br>Baltimore, Md.-21206   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <u>Cardiorespiratory arrest</u><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  | b. <u>Side Sinus Syn. 2<sup>nd</sup> ASCVD</u><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |
|  |  | c.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |
|  |  | d.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Hx. of urepsis</u><br><u>Hx. Parkinson's Disease</u>  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Jaime Punzalan MD   |  |  |  | 29c. LICENSE NUMBER<br>D15124   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/26/90                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>JAIME PUNZALAN 5214 Harford W. Balt. MD. 21218  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



90 26552

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>ANNA VIOLA CARTER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>25</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>7:07 PM</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>218-18-2929</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JULY 31, 1914</b>   | 8. BIRTHPLACE (State or Foreign Country)<br><b>WEST VIRGINIA</b> |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>FRANKLIN SQUARE HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>   |   |
| 10a. STATE<br><b>MARYLAND</b>  |  |  |  | 10b. COUNTY<br><b>BALTIMORE</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>KINGSVILLE</b>                                  |   |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>6853 MT. VISTA ROAD</b>  |  |   |   |
| 10f. ZIP CODE<br><b>21087</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>        |   |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>   |  | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOME MAKER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>RONALD BURTON CONLEY</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>VIRGINIA SWEITZER</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>WILLIAM H. CARTER (HUSBAND)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6853 MT. VISTA ROAD, KINGSVILLE, MARYLAND 21087</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MORELAND MEMORIAL PARK</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>William D. Lewis</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SCHIMUNEK FUNERAL HOME, INC.<br/>9705 BELAIR ROAD, BALTIMORE, MARYLAND 21236</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. ARTERIOSCLEROTIC HEART DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. CARDIAC ARREST</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)      |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dr. Procopio</i> #165  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/25/90</b>                             |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Procopio 9000 Franklin Square Drive Baltimore Maryland 21237</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 90-26553

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Baby Boy CARTER Jack Benny Powell, III</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 9 90</b>  |  | 3. TIME OF DEATH<br><b>2:58 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>—</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>YRS.<br><b>2 13</b>  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>9 9 90</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>USA</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Mercy MEDICAL CENTER</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>  |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  |  |  | 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>413 N PORT Street</b>   |  |
| 10f. ZIP CODE<br><b>21224</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Jack Benny Powell, Jr.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LISA Renee CARTER</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ann Johns</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>B.C./DVR 9/26/91 kam</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | 20c. LOCATION — City or Town, State  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Charles Kresnowski</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Kresnowski FH. 2525 Club St. 21224</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Extreme Prematurity</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. <b>23 week premature (630gm)</b><br>c.<br>d.<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
|   |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  |
|   |  |  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
|   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER<br>(Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>H. Gutierrez MD</b>   |  |  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/9/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>HECTOR H. GUTIERREZ 225 CLARENDON ST BALTO 21201</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendall</b>   |  |  |  |





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90-26554

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>William David Coale Jr.  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-25-90  |  | 3. TIME OF DEATH<br>1:05PM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>079-34-2669   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>48 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>4-3-1942  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>#3 Windmill Chase Rd (Loveton Farms)   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Sparks  |  |
| 9c. COUNTY OF DEATH<br>Baltimore County  |  |  |  | 10a. STATE<br>Md.  |  | 10b. COUNTY<br>Baltimore   |  |
| 10c. CITY, TOWN OR LOCATION<br>SPARKS, Md.   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>3 L. Windmill Chase  |  |
| 10f. ZIP CODE<br>21152   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>High School College  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>State Police   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Md. State Police   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>William David Coale, Sr.  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Thelma V. Kirkley   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Cristine Coale   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3 L Windmill Chase (Loveton Farms) 21152 Sparks, Md.  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Greenmount Crematory   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Md. 21222  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Peter S. Oshko  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Bradley-Ashton Funeral Home, Inc.<br>2134 Willow Spring Rd. Dundalk, Md. 21222   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Contact gunshot wound of mouth   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>9-25-90 FOUND 10:37AM  |  | 28b. TIME OF INJURY<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>Self inflicted wound  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>Home   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>#3 Windmill Chase Rd. Loveton Farms, Baltimore County, MD  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Mario F. Golle, Jr., MD   |  |  |  | 29c. LICENSE NUMBER<br>OCME  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-26-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARIO F. GOLLE, JR., MD 111 Penn Street, Baltimore, MD 21201  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990   |  |  |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000



90 26555

1 - FOR STATE REGISTRAR Thomas E. Carlin  
**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH** REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Carlin, Thomas E.</i> Thomas E. Carlin   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09 24 90  |  | 3. TIME OF DEATH<br>22:57 M  |  |
| 4. SOCIAL SECURITY NUMBER<br>215 01 9659  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>75 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>11/02/14   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>UNION MEMORIAL HOSPITAL   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE   |  |
| 9c. COUNTY OF DEATH   |  |  |  | 10a. STATE<br>Maryland  |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>3546 Beech Ave.  |  |
| 10f. ZIP CODE<br>21211  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>World War 2 |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>College  |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Engineer   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>UNKNOWN  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>UNKNOWN   |  | 19a. INFORMANT'S NAME (Type/Print)<br>Catherine Ford  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2338 Turkey Point Road, Baltimore Maryland 21221                  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Gardens of Faith Cemetery  |  | 20c. LOCATION — City or Town, State<br>Balto., Co. Maryland   |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |
| 22. NAME AND ADDRESS OF FACILITY<br>Bruzdinski Funeral Home P.A.<br>1407 Old Eastern Ave Baltimore Maryland 21221   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Cardio Pulmonary arrest<br>b. Perforated Bowel<br>c. Chronic Renal Failure<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                        |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 6 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)   |  |
| 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> MD  |  | 29c. LICENSE NUMBER<br>N/A   |  |
| 29d. DATE SIGNED (Month, Day, Year)   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>UNION MEMORIAL HOSPITAL BALTIMORE MD.   |  | 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial certificate. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |   | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 90 26556  |  |  |  |
|---|--|--|---|---|--|--|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |  |   | REG. NO.  |  |  |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Elizabeth L. Dudderar   |  |  |   |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 23, 1990             |  | 3. TIME OF DEATH<br>1:00 P M  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>217-14-5520  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>89 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Nov. 23, 1900   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland             |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>3312 Parklawn Ave.  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore  |  |  |  | 9c. COUNTY OF DEATH<br>---  |  |  |  |
| 10a. STATE<br>Maryland  |  |  |   | 10b. COUNTY<br>---  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore                         |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br>3312 Parklawn Ave.  |  |  |   | 10f. ZIP CODE<br>21213  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                        |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) NA<br>College (1-4 or 5+) NA  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker   |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home  |  |  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Noethon   |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Unknown  |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>John W. Dudderar (Son)  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4001 Elmora Ave., Baltimore, Md. 21213   |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Metro Crematory  |   | 20c. LOCATION — City or Town, State<br>Baltimore, Md.   |  |  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Schimunek Funeral Homes, Inc.<br>3331 Brehms Lane, Baltimore, Md. 21213   |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>metastatic lung cancer (to brain)</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |  |   |   |  |  |  | Approximate Interval Between Onset and Death<br>3 years   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>hypertension</u>   |  |  |   |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)                           |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Victoria Vanik MD   |   | 29c. LICENSE NUMBER<br>D32381   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/24/90                   |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Victoria Vanik, Brehms Lane Medical Center, 3400 Brehms Lane, Balto, Md. 21213   |  |  |   |   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990  |  |  |   | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |   |  |  |  |



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

|   |  |  |  |   |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Juanita Dickerson</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>22</b> YEAR <b>90</b>   |  |   |  | 3. TIME OF DEATH<br><b>3:30</b> M   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-20-5233</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>MAY 20, 1913</b>                                  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>LIBERTY MEDICAL CENTER</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE, MD</b>   |  |   |  | 9c. COUNTY OF DEATH   |  |  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |   |  |  |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE, CITY</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><b>2906 N. LOUDON AVE.</b>  |  |  |  | 10f. ZIP CODE<br><b>21216</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                     |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b><br>College (1-4 or 5+) <b>LAB. TECHNICIAN</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>LAB. TECHNICIAN</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>J.H.H</b>  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>EDWARD JONES</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ELLA</b>  |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>STEVEN PINNICK</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8403 OLD FEDERICK RD.-ELLCOTT CITY, 21043</b>   |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST VET. CEM.</b>   |  |   |  | 20c. LOCATION — City or Town, State<br><b>OWINGS MILLS, MD</b>                              |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James Coad</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>  |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Myocardial infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. <b>coronary artery disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. <b>multiple vessel disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>unstable angina</b><br><b>Diabetes Mellitus</b>  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>R. Gordon MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 37874</b>   |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/22/90</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)<br><b>Liberty Medical Center</b>  |  |  |  |   |  |   |  |   |  |  |  |
| 31. DATE (Month, Day, Year)<br><b>SEP 28 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>   |  |   |  |   |  |  |  |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Baltimore, Maryland 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within \_\_\_\_\_ hours after death. Page 6 may be retained by the hospital or attending physician. Page 7 should be retained by the funeral director. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

Page 1 -

RECEIVED  
JAN 11 1961

and your



90 26558

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LILLIAN E. DAVIS</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>26</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>10 25A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-34-748</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Feb. 9, 1903</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Baltimore County General</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Randallstown</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore Co.</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore Co.</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Reisterstown</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>136 Chestnut Hill Lane</b>  |  |
| 10f. ZIP CODE<br><b>21136</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S. A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Oden Dorsey</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ella King</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Raymond Davis</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>804 Overbrook Road Baltimore, Md, 21239</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Burpee-Henss</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Burpee-Henss Funeral Home<br/>3631 Falls Road, Balto. Md 21211</b>   |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIAC ARRHYTHMIA</b><br>Approximate Interval Between Onset and Death <b>0' Mm</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>ARTERIO SCLEROTIC HEART DISEASE</b><br>c. <b>DISEASE</b><br>d. |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>C. Ravi MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D37333</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-26-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>C. RAVI MD, BCGH, RANDALLSTOWN, MD 21133</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>J. Davidson</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

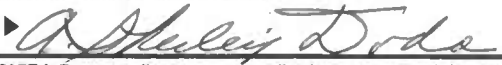
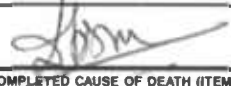

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26559

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PHILLIP BLADEN DULANEY</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 25 90</b>   |  | 3. TIME OF DEATH<br><b>11:19 p. M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>214-03-7054</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>97</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>09/06/1893</b>  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>DVA MEDICAL CENTER</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>FORT HOWARD</b>   |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>   |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>BALTIMORE CITY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>1420 WOODALL ST., BALTIMORE, MD.</b>  |  |  |  | 10f. ZIP CODE<br><b>21230</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW I</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                          |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2 nd</b><br>College (1-4 or 5+) <b></b>   |  | 18a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Construction Worker</b>  |  | 18b. KIND OF BUSINESS/INDUSTRY<br><b>Development</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>PHILLIP DULANEY</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SARAHANN CONWAY</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CLINICAL RECORDS, DVAMC</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GLEN HAVEN CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>CHARLES L. STEVENS FUNERAL HOME, INC.<br/>1501 E. FORT AVE. BALTO., MD 21230</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |   |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |   |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary Artery Disease</b><br><b>COPD</b><br><b>Old Age</b>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
|  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURED   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  | 29c. LICENSE NUMBER<br><b>D30528</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>09/25/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. BALA S. DUGGIRALA M.D., DVA MEDICAL CENTER, FORT HOWARD, MARYLAND 21052</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | REG. NO.   |  |
|---|--|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |  |  | 2. DATE OF DEATH   |  |   |  | 3. TIME OF DEATH   |  |
| Clara R. Drummond   |  |  |  | 9-25-90  |  |   |  | M  |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX   |  | 6. AGE (In yrs. last birthday)   |  | 7. DATE OF BIRTH  |  | 8. BIRTHPLACE (State or Foreign Country)   |  |
| 216-03-4744   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 78 YRS.  |  | 6-23-1912   |  | Balto. MD.   |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |   |  | 9c. COUNTY OF DEATH  |  |
| 3630 Elmora Avenue  |  |  |  | Baltimore  |  |   |  | —  |  |
| 10a. STATE  |  |  |  | 10b. COUNTY  |  |   |  | 10c. CITY, TOWN OR LOCATION  |  |
| MD.   |  |  |  |  |  |   |  | Baltimore  |  |
| 10d. INSIDE CITY LIMITS?  |  |  |  | 10e. STREET AND NUMBER   |  |   |  | 10f. ZIP CODE  |  |
| 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 3630 Elmora Avenue   |  |   |  | 21213  |  |
| 10g. CITIZEN OF WHAT COUNTRY?   |  |  |  | 11. MARITAL STATUS   |  |   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |  |
| U.S.A.  |  |  |  | 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) |  |
|   |  |  |  | 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | IF YES, GIVE WAR OR DATES   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| Elementary/Secondary (0-12)   |  |  |  | College (1-4 or 5+)  |  |   |  | Saleslady  |  |
| 8th GRade   |  |  |  |  |  |   |  | Bonwit Teller  |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |   |  |  |  |
| Leonard George  |  |  |  | Amelia Willinger   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |   |  |  |  |
| Joseph F. Metz III  |  |  |  | 3801 Loch Raven Blvd. Baltimore, MD.-21218   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  |   |  | 20c. LOCATION — City or Town, State  |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State   |  |  |  | Gardens of Faith Cemetery  |  |   |  | Baltimore, Maryland  |  |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  |  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |  |  | 22. NAME AND ADDRESS OF FACILITY   |  |   |  |  |  |
| Kathleen M. Murphy  |  |  |  | John C. Miller, Inc.—6415 Belair Road-21206  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |  |  |  |  |   |  | Unmed.   |  |
| a. Acute Myocardial Infarction  |  |  |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |   |  |  |  |
| b. Congestive Heart Failure   |  |  |  |  |  |   |  | 6 months   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |   |  |  |  |
| c. Coronary Artery Disease  |  |  |  |  |  |   |  | years  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |   |  |  |  |
| d.  |  |  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?   |  |
|   |  |  |  |  |  |   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                      |  |
|   |  |  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?                                  |  |
|   |  |  |  |  |  |   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  |  |  | 26. PLACE OF DEATH (Check only one)  |  |   |  |  |  |
| 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?   |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation  |  |  |  |  |  | M   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 2 <input type="checkbox"/> Accident   |  |  |  |  |  |   |  |  |  |
| 3 <input type="checkbox"/> Suicide  |  |  |  |  |  |   |  |  |  |
| 4 <input type="checkbox"/> Homicide   |  |  |  |  |  |   |  |  |  |
| 8 <input type="checkbox"/> Could not be determined  |  |  |  |  |  |   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                 |  |
|   |  |  |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |   |  | 29c. LICENSE NUMBER  |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                        |  |  |  | J. Rollin Otto, Jr. MD   |  |   |  | DO 9402  |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   |  | 29d. DATE SIGNED (Month, Day, Year)  |  |
|   |  |  |  |  |  |   |  | 9/27/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  | 31. DATE FILED (Month, Day, Year)  |  |   |  | 32. REGISTRAR'S SIGNATURE  |  |
| J. Rollin Otto, Jr. MD 14 West Cold Spring Lane, Balto MD 21210   |  |  |  | SEP 28 1990  |  |   |  | John Davidson-Randall  |  |



90 26561

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Edward J. Finneran Sr.  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09 25 90  |  | 3. TIME OF DEATH<br>1 40 A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>24-20-5259   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>80 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>May 12, 1910                               |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Francis Scott Key Medical Center  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore  |  | 9c. COUNTY OF DEATH<br>---   |  |
| 10a. STATE<br>MD  |  |  |  | 10b. COUNTY<br>---  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>31 S. Ellwood Ave.  |  |  |  | 10f. ZIP CODE<br>21205  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                     |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) NA<br>College (1-4 or 5+) NA  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Weigh Master  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Steel Company   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>James Edward Finneran  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Nannie (Unknown)   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Dianna L. Engle (Friend)  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>513 Kosoak Rd, Baltimore, Md. 21220  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>New Cathedral Cemetery   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Md.   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John F. Collins</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Schimunek Funeral Homes, Inc.<br>3331 Brehms Lane, Baltimore, Md. 21213   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <i>Pneumonia</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Lung Cancer (Squamous cell)</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>COPD Chronic Obstructive Pulmonary Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br><i>5 months</i>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Edema of lungs</i>   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
|   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Stephen Ryan MD Francis Scott Key Medical Center Baltimore MD</i>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>09/28/1990   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-0146  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attended physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1-75-1



90•26562

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Thomas Griffin  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-25-90   |  | 3. TIME OF DEATH<br>12:20 PM  |   |
| 4. SOCIAL SECURITY NUMBER<br>220-03-9202  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>76 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>11-15-13   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>JOHNS HOPKINS HOSPITAL  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE, MD  |  | 9c. COUNTY OF DEATH   |   |
| 10a. STATE<br>MD  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE, CITY  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>1769 Darley Ave.  |  |   |  | 10f. ZIP CODE<br>21213  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK                                  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12th   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>CONSTRUCTION WORKER                |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>THOMAS GRIFFIN   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MARY JANE MOORE  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>ALICE GRIFFIN   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1769 E. DARLEY AVE.-BALTIMORE, MD. 21213   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>GARRISON FOREST VET. CEM  |  | 20c. LOCATION — City or Town, State<br>OWINGS MILLS, MD.  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>James Coad   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>WM.C. MARCH F.H. 1101 E. NORTH AVE.   |  |   |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrest 2* Atherosclerotic Cerebral Vascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Diabetes Mellitus<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>S/P CVA   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO              |   |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |   |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Dorothy Snow   |  |   |  | 29c. LICENSE NUMBER<br>224149   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/26/90  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br>DOROTHY SNOW 3900 LOCH RAVEN BLVD. BALT, MD.  |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

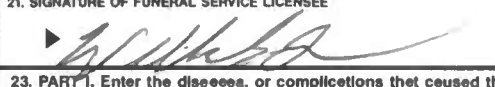
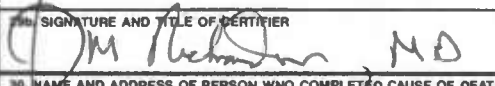

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1911

90 26563

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Norma E. Guido   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9- 26- 1990  |  | 3. TIME OF DEATH<br>10:00 M  |  |
| 4. SOCIAL SECURITY NUMBER<br>219-16-5178   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>65 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>4-25-1925  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |  |  | 9a. FACILITY NAME (If not Institution, give street and number)<br>Francis Scott Key Med. Ctr.  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore   |  |
| 9c. COUNTY OF DEATH<br>-- -- --  |  |  |  | 10a. STATE<br>Md.  |  | 10b. COUNTY<br>Baltimore   |  |
| 10c. CITY, TOWN OR LOCATION<br>Dundalk, Md.  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>216 Maple Ave.   |  |
| 10f. ZIP CODE<br>21222   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>Unknown   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Plant-Mfg.  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>London Fog Rainware  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Heinle   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Grace Jones   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Charles C. Guido, Sr.  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>216 Maple Ave. Dundalk, Md. 21222   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Greenmount Crematory   |  | 20c. LOCATION — City or Town, State<br>Baltimore, MD.  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Bradley-Ashton Funeral Home, Inc.<br>2134 Willow Spring Rd. Dundalk, Md. 21222   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Squamous cell lung cancer   |  |  |  |  |  |  |  |
| b. Smoking cigarettes  |  |  |  |  |  |  |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |  |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> MD  |  |  |  | 29c. LICENSE NUMBER<br>D36430  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/27/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Jeffrey Richardson, MD, 2112 Dundalk, Dundalk, MD 21222   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the funeral permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |  |
| REG. NO. 6:30pm  |  |  |  |   |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ROYAL HATCHETT   |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH 9 DAY 25 YEAR 90  |  | 3. TIME OF DEATH<br>6:30 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>224-26-6138   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>68 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>2/28/22  |  | 8. BIRTHPLACE (State or Foreign Country)<br>VA.  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>CHURCH HOSPITAL  |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore, Md.   |  | 9c. COUNTY OF DEATH<br>Baltimore   |  |
| 10a. STATE<br>Md.  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore City   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br>1528 N. Eden St.   |  |  |  | 10f. ZIP CODE<br>21213  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10th<br>College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>BETHLEHEM STEEL  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>PATRICK HATCHETT  |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>BERTHA FERGUSON  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>GRACE HATCHETT   |  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1528 N. EDEN ST. - BALTIMORE, MD 21213 |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>FERGUSON FUNERAL HOME   |  | 20c. LOCATION — City or Town, State<br>VICTORIA, VIRGINIA   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>[Signature]   |  |  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>WM.C. MARCH F.H. 1101 E. NORTH AVE.   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. END STAGE CARDIOMYOPATHY<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. CHF<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. LYMPHOMA<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                               |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Terance L. Lamb M.D.  |  |   |  | 29c. LICENSE NUMBER<br>D37203   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-25-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>TERANCE LAMB CHURCH Hospital Baltimore, Md. 21231   |  |  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |  |   |  |  |  |



90 26565

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>DONALD J. HOM  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>SEPTEMBER 25, 1990  |  | 3. TIME OF DEATH<br>6:25 A M  |   |
| 4. SOCIAL SECURITY NUMBER<br>217-20-3490   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>77 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>July 28, 1913  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>CHINA  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>St. Joseph Hospital   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Towson   |   |
| 9c. COUNTY OF DEATH<br>Baltimore   |  |  |  | 10. RESIDENCE OF DECEDENT   |  |   |   |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Baltimore   |  | 10c. CITY, TOWN OR LOCATION<br>Towson   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>Manor Care-Ruxton, 7001 N. Charles St.   |  |  |  | 10f. ZIP CODE<br>21204  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Oriental                                 |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 Years<br>College (1-4 or 5+) College   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Owner                              |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Restaurant  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Hom Hopp  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Yiu Kwei Seto  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Frank K.T. Hom   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>139 Warfieldsburg Rd. Westminster, Md. 21157   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Lorraine Park Cemetery   |  | 20c. LOCATION — City or Town, State<br>Woodlawn, Maryland   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>James F. Burnside, Jr.  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Mitchell-Wiedefeld Home, Inc.<br>6500 York Rd. Baltimore, Md. 21212   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute CFA<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic Cardiovascular Disease<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Pneumonia<br>COPD with respiratory failure   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Patricio Gracito, M.D.  |  |  |  | 29c. LICENSE NUMBER<br>168358   |  | 29d. DATE SIGNED (Month, Day, Year)<br>Sept. 25, 1990   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Gracito, Patricio, M.D. 8903 Harford Rd. Baltimore, Md. 21234   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26566

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Constance Impallaria  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>September 27, 1990  |  | 3. TIME OF DEATH<br>10:40 A M  |  |
| 4. SOCIAL SECURITY NUMBER<br>215-12-4102  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>69 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>1-23-21  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND  |  |  |  | 9a. FACILITY NAME (If not Institution, give street and number)<br>Maryland General Hospital   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City  |  |
| 9c. COUNTY OF DEATH   |  |  |  | 10a. STATE<br>MARYLAND  |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>7 S. CURLEY STREET   |  |
| 10f. ZIP CODE<br>21224  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 YEARS<br>College (1-4 or 5+) COLLEGE   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>HOMEMAKER                       |  |
| 16b. KIND OF BUSINESS/INDUSTRY  |  | 17. FATHER'S NAME (First, Middle, Last)<br>FREDERICK MIRRA   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>CONCETTA CITRANO   |  | 19a. INFORMANT'S NAME (Type/Print)<br>MR. CHARLES J. IMPALLARIA  |  |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7 S. CURLEY ST. BALTO. MD. 21224   |  | 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>OAKLAWN CEMETERY  |  | 20c. LOCATION — City or Town, State<br>BALTO. MD.  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Chuck P. Kaczorowski</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br>KACZOROWSKI FUNERAL HOME<br>2525 FLEET ST. BALTO. MD. 21224  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Acute Gastrointestinal Bleed requiring Surgery<br>Diabetes Mellitus       |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO      |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  |
| 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>R. Liberto, M.D.</i>  |  | 29c. LICENSE NUMBER<br>D21464  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br>9-27-90  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Robert T. Liberto, M.D. c/o Maryland General Hospital   |  | 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



7x1  
90-265671 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |   |  |  |  |
|--|--|---|--|---|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Edward T. Johnson  |  |   |  | 2. DATE OF DEATH<br>MONTH 9 DAY 26 YEAR 90  |  | 3. TIME OF DEATH<br>12:40 AM M   |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>218-32-0063   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>82 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>3-15-08                                       |   | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Greater Baltimore Medical Center   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore, MD  |  |  | 9c. COUNTY OF DEATH<br>Baltimore  |  |  |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Baltimore County   |  | 10c. CITY, TOWN OR LOCATION<br>Towson   |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br>7920 Ruxway Road   |  |   |  | 10f. ZIP CODE<br>21204  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WWII  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                       |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12)<br>College (1-4 or 8+)<br>5+   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Accountant   |  |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Federal Gov.'t<br>Gen. Accounting Office |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Charles Eugene Johnson  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Margaret Agnus Murphy  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Virginia B. Johnson  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7920 Ruxway Road, Towson, Maryland 21204   |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Green Mount Cemetery  |  |   | 20c. LOCATION — City or Town, State<br>Baltimore, Maryland                 |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>John G. Reitz   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Mitchell-Wiedefeld Home<br>6500 York Road, Baltimore, MD. 21212   |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiorespiratory Arrest<br>DUE TO (OR AS A CONSEQUENCE OF):<br>(No significant coronary artery disease)<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |  | Approximate Interval Between Onset and Death<br>30-40 min   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Liver tumor, cardiac hypertrophy, old myocardial infarction  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED                    |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Beth R. Schwartz  |  |   |  | 29c. LICENSE NUMBER<br>D38352   |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/27/90  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Beth R. Schwartz, MD GBMC 6701 North Charles Street, Towson, MD 21204   |  |   |  |   |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

10-1-1

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Louise E. Johnson  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-23-90  |  | 3. TIME OF DEATH<br>1:38PM M  |  |
| 4. SOCIAL SECURITY NUMBER<br>215-22-0941   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>76 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>7 10 14   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>4803 Alhambra Avenue  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City  |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br>Maryland   |  |   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br>4803 Alhambra Avenue   |  | 10f. ZIP CODE<br>21212  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: Black   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife                       |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Stanley E. Johnson  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Emma Stokes  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>James Johnson  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4803 Alhambra Avenue Baltimore, Md 21212        |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Maryland National Mem. Ph   |  | 20c. LOCATION — City or Town, State<br>Laurel Maryland   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Leroy Harris  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>1701 McCulloh St.<br>Chatman-Harris F/H Baltimore, Md 21217  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |   | Approximate Interval Between Onset and Death   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |   |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>INQUIRY   |  |   |  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Donald G. Wright  |  |   |  | 29c. LICENSE NUMBER<br>OCME  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-24-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DONALD G. WRIGHT, MD 111 Penn Street, Baltimore, MD 21201   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990   |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson  |  |  |  |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Charles Olney Jacobs  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-24-90   |  | 3. TIME OF DEATH<br>12:34PM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>561-05-7630  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>83 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>4/2/1907  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>1200 E. Fort Avenue   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  | 9c. COUNTY OF DEATH<br>-----  |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>-----  |  | 10c. CITY, TOWN OR LOCATION<br>Balto. City, Md.   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>1439 Haubert St.  |  | 10f. ZIP CODE<br>21230  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>W.W. 2 |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12th. Grade  |  | 15b. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Carpenter                                    |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Merchant Marines  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Charles -- Jacobs  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Sarah --- Kaa'imoku  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Olga scardina   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>954 Shoreland Dr. Glen Burnie, Md. 21061   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Metro Crematory, Inc.   |  | 20c. LOCATION — City or Town, State<br>Catonsville, Md.   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Daniel A. Naylor   |  | 22. NAME AND ADDRESS OF FACILITY<br>Balto. Md. 21230<br>McCully Funeral Home. 130 E. Fort Ave.  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>INSPECTION                                |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>FRANK PERETTI, MD  |  |   |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-25-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>FRANK PERETTI, MD 111 Penn Street, Baltimore, MD 21201   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, it must be filed with the State Dept. of Health and Mental Hygiene prior to the removal of the body. The funeral director must be notified at once.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26570

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Abraham Isaac Kirschenbaum</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>21</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>9 pm</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>117-12-799</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>2-12-04</b>                                    |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Poland</b>  |  |   |  |   |  |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Holy Cross Hospital</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |   |
| 10a. STATE<br><b>Maryland</b>  |  |   |  | 10b. COUNTY<br><b>Montgomery</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>   |   |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   |   |
| 10e. STREET AND NUMBER<br><b>603 Lanark Way</b>  |  |   |  | 10f. ZIP CODE<br><b>20901</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Cartographer</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Army Map Service</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Philip Kirschenbaum</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Hannah Kleinhandler</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ruth K. Kirschenbaum</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>603 Lanark Way, Silver Spring, MD 20901</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>King David Memorial Gdns.</b>  |  | 20c. LOCATION — City or Town, State<br><b>Falls Church, VA</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ives-Pearson Funeral Homes<br/>Falls Church, Virginia 22046</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>aspiration pneumonia</b>  |  |   |  |   |  |   | <b>2 days</b>   |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |   |  |   |  |   |   |
| b. <b>dementia</b>   |  |   |  |   |  |   | <b>5 yrs.</b>   |
| c. <b>atherosclerotic vascular disease</b>   |  |   |  |   |  |   | <b>5 yrs</b>  |
| d.   |  |   |  |   |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   |   |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> M.D.   |  |   |  | 29c. LICENSE NUMBER<br><b>D23762</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/22/90</b>                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Susan Leibenhaut 6525 Belcrest Rd, Hyattsville, Md. 20782</b>  |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as an interment permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|---|--|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>HELEN P KOTULA   |  |  |  | 2. DATE OF DEATH<br>MONTH 09 DAY 26 YEAR 1990   |  | 3. TIME OF DEATH<br>01:38 A M  |   |  |  |
| 4. SOCIAL SECURITY NUMBER<br>215-03-8683   |  | 6. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br>71 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>7-27-19                                    |   | 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  |  | 9c. COUNTY OF DEATH<br>BALTIMORE CITY   |  |  |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |
| 10e. STREET AND NUMBER<br>532 STREEPER STREET  |  |  |  | 10f. ZIP CODE<br>21224  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |   |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                  |   |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8 YEARS   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>HOMEMAKER   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |   |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>MARTIN ZNAMIROWSKI  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>PAULINE PRILL  |  |  |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>MR. JOHN KOTULA  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>532 S. STREEPER ST. BALTO. MD. 21224   |  |  |   |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>HOLY ROSARY CEMETERY   |  | 20c. LOCATION — City or Town, State<br>BALTO. CO. MD.   |  |  |   |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Chuck R. Kaczmarek</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>KACZUROWSKI FUNERAL HOME<br>2525 FLEET ST. BALTO. MD. 21224   |  |  |   |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <i>ischemic cardiomyopathy</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>coronary artery disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>cigarette use</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br><br>Approximate Interval Between Onset and Death<br>4 yrs.<br>40 yrs.<br>50 yrs. |  |  |  |   |  |  |   |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED                    |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John Mark Davidson, M.D.</i>   |  |   |  | 29c. LICENSE NUMBER  |   | 29d. DATE SIGNED (Month, Day, Year)<br>9/26/90       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>J.M. Michon, M.D. Johns Hopkins Hospital Baltimore, M.D.</i>   |  |  |  |   |  |  |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |  |  |   |  |  |



90 26572

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Ethel C. Kleinsmith  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 24, 1990  |  | 3. TIME OF DEATH<br>M   |   |
| 4. SOCIAL SECURITY NUMBER<br>216-18-6261   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>66 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>5/2/1924  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>119 E. Randall St.  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Balto. City, Md.   |  | 9c. COUNTY OF DEATH<br>-----  |   |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>-----  |  | 10c. CITY, TOWN OR LOCATION<br>Balto. City, Md.   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>119 E. Randall St.   |  | 10f. ZIP CODE<br>21230  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>9th. Grade  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Garner ----- Speer  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anna --- Tolson  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. August L. Kleinsmith   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>119 E. Randall St. Balto. Md. 21230  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery   |  | 20c. LOCATION — City or Town, State<br>A.A. Co. Md.   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Daniel A. Taylor  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Balto. Md. 21230<br>McCully Funeral Home, 130 E. Fort Ave.  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. METASTATIC BREAST CA<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
|  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |   |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>John J. Klassen M.D.  |  |   |  | 29c. LICENSE NUMBER<br>D-20483  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/24/90  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>STENGER. G. CASSIN.   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson Randall  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the cause of death be ascertained by a physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |                     |  |                                     |  |
|---|--|--|--|--|--|---|--|---|--|---|--|--|--|---------------------|--|-------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Laura F. Lair</u>  |  |  |  |  |  | 2. DATE OF DEATH<br>MONTH <u>9</u> DAY <u>25</u> YEAR <u>90</u>   |  |   |  | 3. TIME OF DEATH<br><u>1:50 a.m.</u>  |  |  |  |                     |  |                                     |  |
| 4. SOCIAL SECURITY NUMBER<br><u>217-14-0608</u>   |  |  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><u>68</u> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>2/5/22</u>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><u>Maryland</u>   |  |  |  |                     |  |                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>Good Samaritan Hospital</u>  |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Baltimore</u>   |  |   |  | 9c. COUNTY OF DEATH   |  |  |  |                     |  |                                     |  |
| 10a. STATE<br><u>md.</u>  |  |  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><u>Baltimore</u>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |                     |  |                                     |  |
| 10e. STREET AND NUMBER<br><u>6408 Fair Oaks Ave.</u>  |  |  |  |  |  | 10f. ZIP CODE<br><u>21214</u>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |  |  |                     |  |                                     |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>White</u> |  |                     |  |                                     |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><u>12 yrs.</u>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Book keeper</u>          |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |  |  |                     |  |                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>LOUIS Przybylowski</u>  |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Victoria Novak</u>  |  |   |  |   |  |  |  |                     |  |                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Alfreda Kennedy</u>  |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>6408 Fair Oaks Ave. Balto. Md 21214</u> |  |   |  |   |  |  |  |                     |  |                                     |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Baltimore National Cem. Balto. Md.</u>                          |  |   |  | 20c. LOCATION — City or Town, State<br><u>Balto. Md.</u>  |  |   |  |  |  |                     |  |                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Andrew L. David</u>   |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>Lilly &amp; Zeiler Inc. 1901 Eastern Ave 21231</u>   |  |   |  |   |  |  |  |                     |  |                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Terminal cancer (Oesoph. ca. &amp; mult. Met.)</u>  |  |  |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |  |  |                     |  |                                     |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |  |  |   |  |   |  |   |  |  |  |                     |  |                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |                     |  |                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |                     |  |                                     |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |                     |  |                                     |  |
|   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |                     |  |                                     |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |   |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>P. J. Matthews P.D.</u>   |  |  |  | 29c. LICENSE NUMBER |  | 29d. DATE SIGNED (Month, Day, Year) |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |  |  |   |  |   |  |   |  |  |  |                     |  |                                     |  |
| 31. DATE FILED (Month, Day, Year)<br><u>SEP 28 1990</u> <u>Julia Davidson-Randall</u>   |  |  |  |  |  |   |  |   |  |   |  |  |  |                     |  |                                     |  |





4H 90 26574

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Dennis Ellis MCCAUSLAND</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 24, 1990</b>   |  | 3. TIME OF DEATH<br><b>2:15 P M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>218-32-4430</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>53</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>May 22, 1937</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Franklin Square Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rossville</b>  |   |
| 9c. COUNTY OF DEATH<br><b>Baltimore County</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY  |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>3420 Mary Ave. Apt. A</b>   |   |
| 10f. ZIP CODE<br><b>21214</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1955-1958</b>  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Security Guard</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Pinkerton/CCP</b>   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas McCausland</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Vada A. Gowl</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Virginia L. McCausland</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3420 Mary Ave. Apt. A, Baltimore, MD 21214</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>George Altun</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ROBERT C. ALTENBURG FUNERAL HOME, INC.<br/>6009 Harford Rd., Baltimore, MD 21214</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute Hemorrhage of Innominate Artery</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Squamous cell carcinoma of esophagus (recurrent)</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Pseudomonas Pneumonia of left lung</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b> |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Carlos A. Almedia, MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>N/A</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/24/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Carlos A. Almedia, MD 9000 Franklin Square Drive 21237</b>  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>   |  |  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

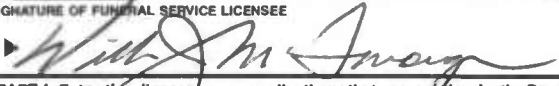
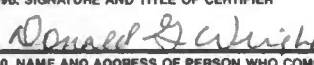
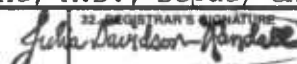
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |   |
|--|--|--|--|--|--|---|---|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>JAMES ROBERT MCCAULEY</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 22 90</b>   |  | 3. TIME OF DEATH<br><b>9:05 A M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>579-40-8340</b>  |  | 5. SEX<br><b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>  |  | 6. AGE (In yrs. last birthday)<br><b>58 YRS.</b>   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>May 28, 1932</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  |  |  |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>7551 New Hampshire Avenue</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Langley Park</b>   |  | 9c. COUNTY OF DEATH<br><b>Prince George's</b>   |   |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Prince George's</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Takoma Park</b>  |  | 10d. INSIDE CITY LIMITS?<br><b><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>                          |   |
| 10e. STREET AND NUMBER<br><b>211 Lincoln Avenue</b>  |  |  |  | 10f. ZIP CODE<br><b>20912</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S. of A.</b>  |   |
| 11. MARITAL STATUS<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br/>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced</b>   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b><br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:</b> |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Caucasian</b>  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 8</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Plumber &amp; Handyman</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>General Maintenance</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph E. McCauley</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ruth E. Hanes</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ann Bramhall</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Rt. 2, Box 73 Lovettsville, Va. 22080</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Union Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Lovettsville, Va.</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Brown Funeral Home<br/>P.O. Box 320, Lovettsville, Va. 22080</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Head Injury</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b><br>(Head Only)                               |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>   |  |  |  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b> |
| 26. PLACE OF DEATH (Check only one)<br><b>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br/>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>Scene</b></b>  |  | 27. MANNER OF DEATH<br><b>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Pending Investigation<br/>3 <input checked="" type="checkbox"/> Accident 4 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Could not be determined 6 <input type="checkbox"/> Homicide</b> |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>Found 9-22-90/8:50 A M</b>  |  | 28b. TIME OF INJURY<br><b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>                             |   |
| 28c. INJURY AT WORK?<br><b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>   |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Subject fell and struck head</b>   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>outside (behind car wash)</b>   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>7551 New Hampshire Avenue, P.G. County, MD</b> |   |
| 29a. CERTIFIER (Check only one)<br><b>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>   |  |  |  |  |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>OCME</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-23-90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Donald G. Wright, M.D., Deputy Chief 111 Penn Street, Baltimore, MD 21201 vl</b>   |  |  |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the funeral director, page 5 should be detached for use in the funeral-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the funeral director, page 5 should be detached for use in the funeral-transit permit.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 26576

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Frederick A. Metzger</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 25, 1990</b>  |  | 3. TIME OF DEATH<br><b>M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215 07 5974</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10/22/18</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>400 Stemmers Run Road</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Essex</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  |   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Essex</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br><b>400 Stemmers Run Road</b>   |  | 10f. ZIP CODE<br><b>21221</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>usa</b>   |  |   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>World War 2</b> |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>A</b>  |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b></b>                               |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Sales</b>  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Distributing Company</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frederick Metzger</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Augusta Willey</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dolores Metzger (wife)</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>400 Stemmers Run Road, Baltimore Maryland 21221</b>                        |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b></b>   |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore County, Md</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Brudzinski Funeral Home P.A.<br/>1407 Eastern Ave. Baltimore Maryland 21221</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>a. Ischemic heart disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Prior myocardial infarctions</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Complete heart block/permanent pacemaker</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. Congestive heart failure</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |   |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>24a. WAS AN AUTOPSY PERFORMED?</b><br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><b>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?</b><br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b></b> |  |  |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>NONE</b>   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> MD  |  |   |  | 29c. LICENSE NUMBER<br><b>D26253</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/25/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>LARRY WILSON, MD. 9020 Franklin Square Dr, Baltimore, Md 21237</b>  |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |




TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br>Evelyn Mc Nutt   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-25-90   |  | 3. TIME OF DEATH<br>2:05AM M  |  |
| 4. SOCIAL SECURITY NUMBER<br>214-26-8413   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>62 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>3-13-1928   |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br>2738 HARLEM AVENUE   |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY   |  | 8c. COUNTY OF DEATH<br>Md   |  |
| 10a. STATE<br>Md   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>2738 Harlem Avenue   |  |  |  | 10f. ZIP CODE<br>21216  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U S A  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                                    |  |
| 15. DECEASED'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)   |  | 16a. DECEASED'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)                                    |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Bracey LaBoard  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Marie Nesbit   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Georgia Stainback  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3028 Arunah Avenue Baltimore, Md 21216   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Arbutus Memorial Park  |  | 20c. LOCATION — City or Town, State<br>Arbutus, Md  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>March F/H West<br>4300 Wabash Avenue  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic cardiovascular disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>INQUIRY |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>XXX YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES XX NO  |
| 27. MANNER OF DEATH<br>XXX Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-25-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>FRANK PERETTI, MD 111 Penn Street, Baltimore, MD 21201  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 27 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26578

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>VIRGINIA M MACKENZIE</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>25</b> YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>10:07 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220203143</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>2/18/27</b>                              |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Harbor Hospital Center</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| 10a. STATE<br><b>MD</b>   |  |   |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>                                  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br><b>LIGHT ST, 1450</b>   |  |   |  |
| 10f. ZIP CODE<br><b>21230</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>               |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>8th Grade</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Retired Laborer</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>General chemical</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Sherman -- Schools</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lucy Burd</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Lucy E. Hammond</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1749 Clarkson St Balto Md 21230</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemt.</b>   |  | 20c. LOCATION — City or Town, State<br><b>A.A.Co.Md.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>David A. Taylor</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Balto.Md.21230<br/>McCully Funeral Home, 130 E. Fort Ave.</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. hypovolemia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. probable esophageal varices</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Liver Cirrhosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)          |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Piotr L. Grojec, MD</b>  |
| 29c. LICENSE NUMBER   |  |   |  |   |  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9.25.1990</b>  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Piotr L. Grojec, House Staff, Harbor Hospital Center</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Pages 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | REG. NO.  |   |
|--|--|--|--|---|---|
| 1 - FOR STATE REGISTRAR  |  |  |  | 90 26579  |   |
| CERTIFICATE OF DEATH   |  |  |  |   |   |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mary E. Nies   |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 27 YEAR 90   |   | 3. TIME OF DEATH<br>5:37 A M  |
| 4. SOCIAL SECURITY NUMBER<br>219-30-1008   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. & birthday)<br>75  |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>11/28/14  |
| 8a. FACILITY NAME (If not Institution, street and number)<br>Francis Scott Key Medical Center  |  |  | 8b. CITY, TOWN OR LOCATION OF DE<br>Baltimore  |   | 8c. COUNTY OF DEATH<br>Maryland   |
| 9a. STATE<br>MD  |  | 9b. COUNTY<br>Baltimore  |  | 9c. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |   |
| 10a. STREET AND NUMBER<br>24 North Streeper Street   |  | 10b. ZIP CODE<br>21224   |  | 10c. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |   |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white  |  |  |  |   |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>unknown   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>homemaker   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>own home  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Norman Snyder   |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Bertha Nehring  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Russell Nies   |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>24 N. Streeper St/Balto. MD 21224 |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Parkwood Cemetery  |  | 20c. LOCATION — City or Town, State<br>Baltimore, MD  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Moran-Ashton Funeral Home, Inc.<br>3000 E. Baltimore St., Balto. Md. 21224                     |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiopulmonary Arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <i>Cerebrovascular</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death |  |  |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i># Cervix</i>  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
|  |  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES <input type="checkbox"/> NO   |   |
|  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |   |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Staff Physician</i>  |  |  | 29c. LICENSE NUMBER<br>D38836  |   | 29d. DATE SIGNED (Month, Day, Year)<br>9/27/90  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Kreshy up 490 Eastern Ave Balto MD 21224</i>   |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990   |  |  |  |   |   |



90 26580

FOR  
STATE  
REGISTRAR Alethea M. Nies  
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH  
REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Alethea M. NIES</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 / 27/90</b>  |  | 3. TIME OF DEATH<br><b>8:15 A M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>216 09 2499</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>85 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>04/23/05</b>                                      |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9. COUNTY OF DEATH<br><b>Baltimore county</b>   |  |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rossville 21237</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore county</b>  |   |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Essex</b>   |   |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>16 Berkshire Road</b>  |  |   |   |
| 10f. ZIP CODE<br><b>21221</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5</b><br>College (1-4 or 5+) <b>Housewife</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Richard Jenkins</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Alice Lawton</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ethel Szczepaniak</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>86 Berkshire Road Baltimore Md 21221</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Gardens of Faith Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore Co., Md</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bruzdinski Funeral Home PA<br/>1407 Old Eastern Ave Baltimore Md 21221</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Intracerebral hemorrhage</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>NONE</b>  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D26253</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/27/90</b>                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>9000 Franklin Square Drive, Baltimore, Md. 21237</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26581

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

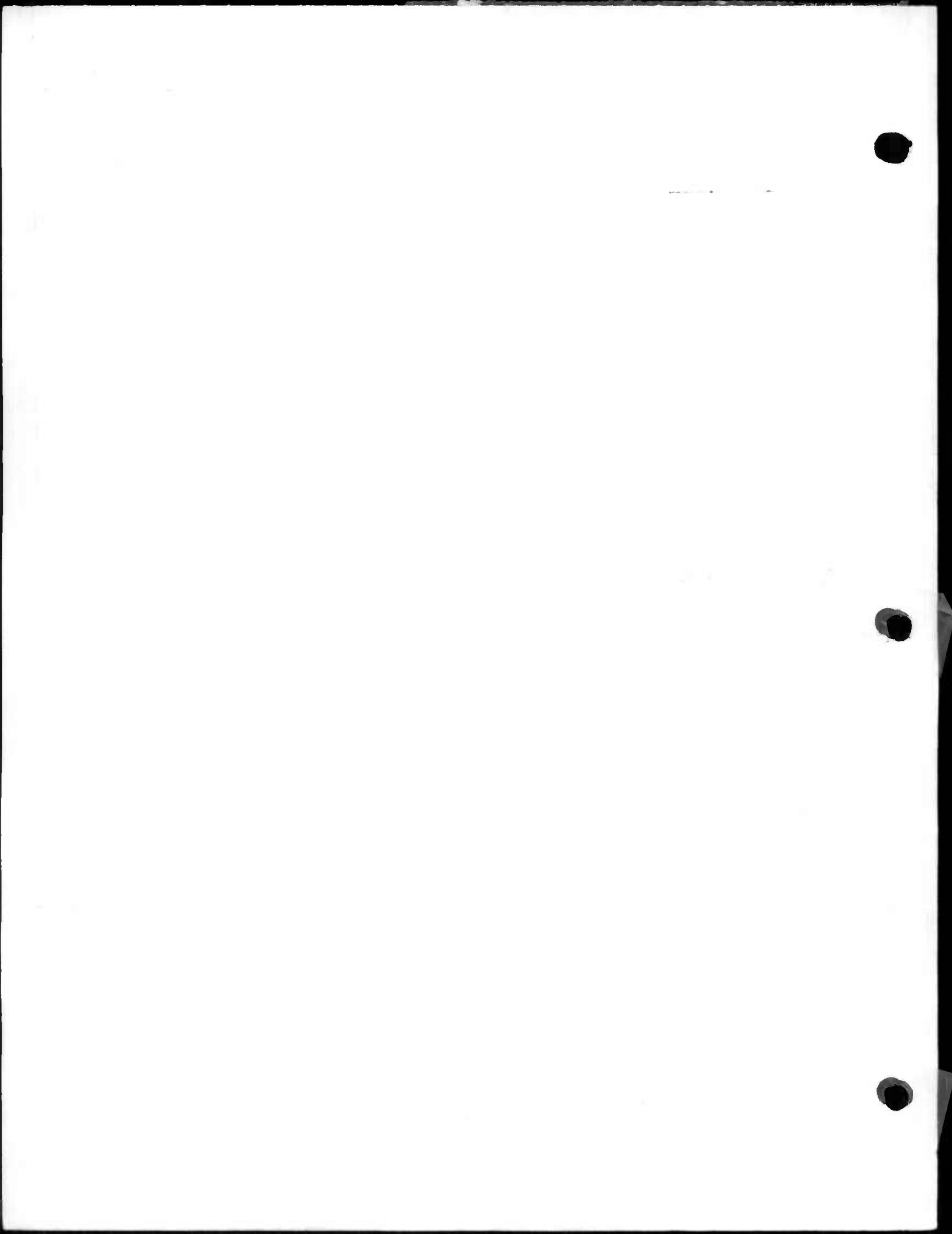
|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARIE D. Ostrowski</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9-26-90</b>  |  | 3. TIME OF DEATH<br><b>10 A M</b>   |   |
| 4. <b>216-05-9769</b><br><b>216-05-9765</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>8-05-15</b>  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>CHURCH HOSPITAL CORPORATION</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH   |   |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |   |   |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET ADDRESS<br><b>26 North Ellwood Avenue</b>   |  |   |  | 10f. ZIP CODE<br><b>21224</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                          |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (8-12) <b>unknown</b><br>College (1-4 or 5+) <b>unknown</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>own home</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Anthony Kucinski</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Alexandra Sumowska</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Edward Ostrowski, Sr.</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>26 N. Ellwood Ave/Balto. MD 21224</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holy Rosary Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Moran-Ashton Funeral Home, Inc.</b><br><b>3000 E. Baltimore St/Balto. MD 21224</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Acute CVD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Severe atherosclerosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Coronary artery disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
|   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28e. DESCRIBE NOW INJURY OCCURRED   |  |   |   |
|   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |   |  | 29c. LICENSE NUMBER<br><b>008355</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/26/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>GRACIA V. PATRINO</b>   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26582

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Keyshawna PAGE</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>24</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>235 P M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>—</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>YRS. <b>6</b>   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>9/18/90</b>                             |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>University of Maryland Hospital</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |   |
| 10a. STATE<br><b>MD</b>  |  |   |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                      |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>3414 Edmondson Ave</b>   |  |  |   |
| 10f. ZIP CODE<br><b>21229</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |   |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:                           |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>—</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>None</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>—</b>  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Keyon (Cary) CAREY</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Theresa PAGE</b>  |  |  |   |
| 19a. INFORMANT'S NAME<br><b>Julia Miles</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3412 Edmondson Ave./Baltimore, MD</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Western Star Cem.</b>  |  | 20c. LOCATION — City or Town, State<br><b>Catonsville, MD.</b>  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Vanessa Coad</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Wm. C. March Funeral Home<br/>1101 E. North Avenue 21202</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |  |   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>Cardiopulmonary Arrest</b>  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>10 min</b> |
|  |  | b. <b>Hypoxia</b>   |  |   |  |  | <b>20 min</b>   |
|  |  | c. <b>Myocardial Failure</b>  |  |   |  |  | <b>20 min</b>   |
|  |  | d. <b>Hypoplastic left heart syndrome</b>   |  |   |  |  | <b>Congenital</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  |   |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <b>1</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John G. Laschinger MD</b>   |  | 29c. LICENSE NUMBER<br><b>D40372</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/24/90</b>                                |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John G. Laschinger MD 22 South Greene St Baltimore MD 21201</b>  |  |   |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>9/24/90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-inquest permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

21-11-11

90 26583

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Helen M. Raczowski   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-25-90   |  | 3. TIME OF DEATH<br>9:32 A M  |  |
| 4. SOCIAL SECURITY NUMBER<br>217-32-8020   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br>82 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Aug..3, 1908  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Francis Scott Key Medical Center   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore  |  | 9c. COUNTY OF DEATH<br>-- -- --   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>-- -- --  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>5318 Wright Ave.   |  |  |  | 10f. ZIP CODE<br>21205  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U. S. A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) NA<br>College (1-4 or 5+) NA   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker                       |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Unknown Sobiek  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Unknown  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Stephen F. Raczowski (Husband)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5318 Wright Ave, Baltimore, Md. 21205  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>St. Stanislaus   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Md.   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Harvey Bain</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Schimunek Funeral Homes, Inc.<br>3331 Brehms Lane, Baltimore, Md. 21213   |  |   |  |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIAC ARREST</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. <u>AORTIC STENOSIS, PROBABLE CORONARY HEART DISEASE</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u>HEART DISEASE</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Sheldon Gottlieb, M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br>216362   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-25-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Sheldon Gottlieb, M.D. 4940 Eastern Ave, Baltimore, Maryland 21224  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>J. Davidson-Randall</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26584

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BERTHA RICHARDSON</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>22</b> YEAR <b>1990</b>  |  | 3. TIME OF DEATH<br><b>12:00P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>249-46-1633</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>08/20/14</b>                               |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>SOUTH CAROLINA</b>   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>G.B.M.C., 6701 N. CHARLES STREET</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TOWSON</b>                                 |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  |   |  | 10a. STATE<br><b>MARYLAND</b>   |  |  |  |
| 10b. COUNTY<br><b>BALTIMORE</b>   |  |   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  |  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br><b>449 PITTMAN PLACE</b>  |  |  |  |
| 10f. ZIP CODE<br><b>21202</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>              |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Cook</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Wright</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Grant</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Delores Ross</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2746 The Alameda Baltimore, Maryland 21218</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Ashley Baptist Church Cem, Charleston, S.C.</b>  |  | 20c. LOCATION — City or Town, State   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Gray Hurley</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Chatman-Harris F/H Baltimore, Md 21217</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Renal Failure</b>  |  |   |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  |   |  |   |  |  |  |
| b. <b>Small Bowel Obstruction</b>   |  |   |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |  |  |
| c. <b>Hypertension; Hypotensive Encephalopathy</b>  |  |   |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |  |  |
| d.  |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension; Hypotensive Encephalopathy</b>   |  |   |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Roger Theodore M.D.</b>   |  |   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Roger Theodore M.D.</b>   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13149, BALTIMORE, MARYLAND 21203-0149

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26585

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WILMA A. SKEEN</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9-26-90</b>  |  | 3. TIME OF DEATH<br><b>6:18 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-36-8119</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>54</b> YRS.  |  | 7. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JULY 20, 1936</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>CHURCH HOSPITAL CORPORATION</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  |
| 9c. COUNTY OF DEATH<br>- - - -  |  |  |  | 10a. STREET AND NUMBER<br><b>215 N. LINWOOD AVE</b>   |  | 10b. ZIP CODE<br><b>21224</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>NA</b><br>College (1-4 or 5+) <b>NA</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WINFRED SEYMOUR</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>IDA ANNA MIELNICKI</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>LAURA LYNN BRACKETT (DAUGHTER)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>400 LORRAINE AVE., BALTIMORE, MD. 21221</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GARDENS OF FAITH</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SCHIMUNEK FUNERAL HOMES, INC.</b><br><b>3331 BREHMS LANE, BALTIMORE, MD. 21213</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>MYOCARDIAL INFARCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>ASHD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>minutes</b><br><b>hrs.</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES MELLITUS</b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>SEP 26 1990</b>  |  | 28b. TIME OF INJURY<br><b>M</b>   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>015135</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/24/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>100 N. BRADDOCK BALTIMORE, MD 21231</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26586

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |                                |  |  |  |  |  |  |    |                                |  |    |                              |    |                              |    |                              |
|--|--------------------------------|--|--|--|--|--|--|----|--------------------------------|--|----|------------------------------|----|------------------------------|----|------------------------------|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>AMELIA SIMMONS (NICHOLS)</b>  |                                |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>26</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>M</b>   |  |    |                                |  |    |                              |    |                              |    |                              |
| 4. SOCIAL SECURITY NUMBER<br><b>247-60-3389</b>  |                                | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>6-10-04</b>  |  |    |                                |  |    |                              |    |                              |    |                              |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1556 WAVERLY WAY</b>  |                                |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>   |  | 9c. COUNTY OF DEATH  |  |    |                                |  |    |                              |    |                              |    |                              |
| 10a. STATE<br><b>MD</b>  |                                |  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>   |  |    |                                |  |    |                              |    |                              |    |                              |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |                                |  |  | 10e. STREET AND NUMBER<br><b>1556 WAVERLY WAY</b>  |  | 10f. ZIP CODE<br><b>21239</b>  |  |    |                                |  |    |                              |    |                              |    |                              |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                |  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |    |                                |  |    |                              |    |                              |    |                              |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |                                |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>   |  |  |  |    |                                |  |    |                              |    |                              |    |                              |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>11th Grade</b><br>College (1-4 or 5+) <b>Housewife</b>   |                                |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |    |                                |  |    |                              |    |                              |    |                              |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joe Briggs</b>   |                                |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Alminia Amos</b>   |  |  |  |    |                                |  |    |                              |    |                              |    |                              |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Marie R. Weeks</b>  |                                |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1556 WAVERLY WAY/BALTIMORE, MD. 21239</b>                                  |  |  |  |    |                                |  |    |                              |    |                              |    |                              |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                                |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Anne Arundel Co., Md.</b>  |  |    |                                |  |    |                              |    |                              |    |                              |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Unesa Coal</i>   |                                |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C. MARCH F.H. 1101 E. NORTH AVENUE 21202</b>   |  |  |  |    |                                |  |    |                              |    |                              |    |                              |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><table border="0"> <tr> <td>a.</td> <td><b>Coronary artery embolus</b></td> <td rowspan="4">           Approximate Interval Between Onset and Death         </td> </tr> <tr> <td>b.</td> <td><b>Myocardial infarction</b></td> </tr> <tr> <td>c.</td> <td><b>Myocardial infarction</b></td> </tr> <tr> <td>d.</td> <td><b>Myocardial infarction</b></td> </tr> </table> |                                |  |  |  |  |  |  | a. | <b>Coronary artery embolus</b> | Approximate Interval Between Onset and Death | b. | <b>Myocardial infarction</b> | c. | <b>Myocardial infarction</b> | d. | <b>Myocardial infarction</b> |
| a.   | <b>Coronary artery embolus</b> | Approximate Interval Between Onset and Death   |  |  |  |  |  |    |                                |  |    |                              |    |                              |    |                              |
| b.   | <b>Myocardial infarction</b>   |  |  |  |  |  |  |    |                                |  |    |                              |    |                              |    |                              |
| c.   | <b>Myocardial infarction</b>   |  |  |  |  |  |  |    |                                |  |    |                              |    |                              |    |                              |
| d.   | <b>Myocardial infarction</b>   |  |  |  |  |  |  |    |                                |  |    |                              |    |                              |    |                              |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CVA - acute</b>   |                                |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |    |                                |  |    |                              |    |                              |    |                              |
|  |                                |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO      |  |    |                                |  |    |                              |    |                              |    |                              |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |                                | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |    |                                |  |    |                              |    |                              |    |                              |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |                                | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |    |                                |  |    |                              |    |                              |    |                              |
|  |                                | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |    |                                |  |    |                              |    |                              |    |                              |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |                                |  |  |  |  |  |  |    |                                |  |    |                              |    |                              |    |                              |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Marie R. Weeks</i>   |                                |  |  | 29c. LICENSE NUMBER<br><b>D18847</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>6/28/90</b>  |  |    |                                |  |    |                              |    |                              |    |                              |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Marie R. Weeks, 1556 Waverly Way, Baltimore, MD 21239</b>  |                                |  |  |  |  |  |  |    |                                |  |    |                              |    |                              |    |                              |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 20 1990</b>  |                                |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |  |    |                                |  |    |                              |    |                              |    |                              |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90.26587

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CARROLL M. SHENTON</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> - DAY <b>26</b> - YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>12:30 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>238-05-7807</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>79</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>7-29-11</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>STELLA MARIS</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TOWSON</b>   |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Towson</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>1519 Dellsway Road</b>  |  |
| 10f. ZIP CODE<br><b>21204</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Office Manager</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Shell Oil Company</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Marion Austin Shenton Sr.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rosa Mae Schafer</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Margaret N. Shenton</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1519 Dellsway Road Towson, Maryland 21204</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Sater's Baptist Church Cemetery</b>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>Lutherville, Maryland</b>  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Dennis Stephen Xenakis</b>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Mitchell-Wiedefeld Home 6500 York Road 21212</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ALZHEIMER'S</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>ARTERIOSCLEROSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>URINARY TRACT INFECTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Eddie Nakhuda</b>  |  |  |  |
| 29c. LICENSE NUMBER<br><b>D15504</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-26-90</b>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>EDDIE NAKHUDA STELLA MARIS 2300 DULANEY VALLEY RD. 21204</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Juha Davidson-Randall</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26588

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DANIEL RUSSELL SPRECHER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 23, 1990</b>   |  | 3. TIME OF DEATH<br><b>4:00 AM</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>171 20 9608</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>59</b> YRS. |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Aug. 21, 1931</b> |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b> |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>7060 Ocean Pines</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Berlin</b>  |  | 9c. COUNTY OF DEATH<br><b>Worcester</b>   |   |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |   |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Worcester</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Berlin</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>7060 Ocean Pines</b>   |  |  |  | 10f. ZIP CODE<br><b>21811</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>11 yrs</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Sales- Circulation</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Newspaper Publishing</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Howard Sprecher</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elizabeth Ulrich</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Beverly H. Sprecher</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7060 Ocean Pines Berlin, MD 21811</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Annville Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Annville, Pa.</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>BURBAGE FUNERAL HOME<br/>108 Williams ST.<br/>Berlin, MD 21811</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |   |   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  | a. <b>Metastatic Lung Cancer</b>   |  |   |  |   | Approximate Interval Between Onset and Death<br><b>6 months</b> |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  | b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |   |
|   |  | c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |   |
|   |  | d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
|   |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |   |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |   |   |
| 29a. CERTIFIER<br>(Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> M.D.  |  |  |  | 29c. LICENSE NUMBER<br><b>030690</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/24/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. James E. Martin, M.D. 145 E. Carroll St. Salisbury, MD 21801</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26589

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |   |  |
|---|--|---|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MILDRED J. SWARTZ   |  |   |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9- 24- 90   |  | 3. TIME OF DEATH<br>M   |  |
| 4. SOCIAL SECURITY NUMBER<br>217-03-5068A   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br>93 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>5-16-1897   |  | 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>CATON HARBOR NURSING HOME   |  |   |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  | 9c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT   |  |   |   |   |  |   |  |
| 10a. STATE<br>MARYLAND  |  | 10b. COUNTY   |   | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>603 S. BELNORD AVENUE   |  |   |   | 10f. ZIP CODE<br>21224  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8 YEARS  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>SEAMSTRESS   |   | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOHN RANDALL   |  |   |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>JULIA CASEY  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>MRS. BARBARA BAYNES   |  |   |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>643 S. KENWOOD AVENUE BALTO. MD. 21224   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>LOUDON PARK   |   | 20c. LOCATION — City or Town, State<br>BALTO. MD.   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Jack R. Kaczorowski</i>   |  |   |   | 22. NAME AND ADDRESS OF FACILITY<br>KACZOROWSKI FUNERAL HOME<br>2525 FLEET STREET BALTO. MD. 21224  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Carcinoma of the SIGMOID COLON</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |   |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
|   |  |   |   |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |   | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
|   |  |   |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Melito M. Torres</i>  |  |   |   | 29c. LICENSE NUMBER<br>211150   |  | 29d. DATE SIGNED (Month, Day, Year)<br>Sept 27, 1990  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MELITO M. TORRES, MD, 441 S. ELLWOOD AVE BALTO, MD 21224   |  |   |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990  |  |   |   | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26590

|   |  |  |  |   |   |   |   |  |  |
|---|--|--|--|---|---|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Frederick Simonaire</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 19 90</b>   |   | 3. TIME OF DEATH<br><b>2:55 p.m.</b>  |   |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-05-1505</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.  |   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12-04-14</b>                                      |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Md.</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1134 Newfield Rd.</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balto.</b>  |   |   |   | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>Md.</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |   |   |   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>1134 Newfield Rd.</b>  |  |  |  | 10f. ZIP CODE<br><b>21207</b>   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE YEAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |   |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>engineer</b>                 |  |   | 15b. KIND OF BUSINESS/INDUSTRY<br><b>railroad</b> |   |   |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Julius Simonaire</b>  |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lena Caroline</b>   |   |   |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary Simonaire</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1134 Newfield Rd. Balto. Md. 21207</b>  |   |   |   |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | 20c. LOCATION — City or Town, State   |   |   |   |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board Balto. Md.</b>   |   |   |   |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lung Cancer</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>Bone Metastases</b><br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br> |  |  |  |   |   |   | Approximate Interval Between Onset and Death                            |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 29a. CERTIFIER<br>(Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |   | 29c. LICENSE NUMBER<br><b>024356</b>  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/21/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Wm. C. Waterfield MD St. Agnes Hosp 900 Cato Ave Balt Md 21229</b>  |  |  |  |   |   |   |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |   |   |   |  |  |

State Anatomy Board Balto. Md.

*Edward W. Allen*

90 26591

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>William H. Seebach Sr.   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 23, 1990   |  | 3. TIME OF DEATH<br>M  |  |
| 4. SOCIAL SECURITY NUMBER<br>218-09-5930   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>73 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>8/21/1917  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>1118 S. Paca St.   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Balto. City, Md.  |  |
| 9c. COUNTY OF DEATH<br>-----   |  |   |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>-----   |  |
| 10c. CITY, TOWN OR LOCATION<br>Balto. City, Md.  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>1118 S. Paca St.   |  |
| 10f. ZIP CODE<br>21230   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>Unknown -----   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Cabinet Maker  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Gov't GSA  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Henry --Seebach   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Josephine ---- Eber   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. William H. Seebach, Jr.  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1106 Paca St. Balto. Maryland 21230   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Loudon Park Cemetery  |  | 20c. LOCATION — City or Town, State<br>Balto. Md   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>David A. Taylor</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Balto. Md. 21230<br>McCully Funeral Home, 130 E. Fort Ave.   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <u>METASTATIC COLON CARCINOMA</u>  |  |  |  | Approximate Interval Between Onset and Death<br>3 months   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  | b. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |
|  |  | c. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |
|  |  | d. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robert W. Bailey MD</i>  |  |   |  | 29c. LICENSE NUMBER<br>D31274  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/26/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Robert W. Bailey, M.D.  |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rendell</i>  |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEMS:6,7 per FH G-668  
10-2-90 cm

90 26592

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Everett T. Steed, Jr.</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 24, 1990</b>  |  |  |  | 3. TIME OF DEATH<br><b>6:35 P M</b>   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212 24 7973</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>61</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 15, 1929</b>               |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Washington DC</b>                            |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Harbor Hospital Center</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>Baltimore, City</b>   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Pasadena</b>                             |  |   |  |   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>662 B St.</b>   |  | 10f. ZIP CODE<br><b>21122</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                       |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>World War II</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>12</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Plumber</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Railroad Company</b>                  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Everett T. Steed, Sr.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary McElroy</b>   |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Rose Marie Steed</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>662 B St., Pasadena, Maryland 21122</b>  |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedarwood Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Edinburg, VA</b>   |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Stephen D. Lohman</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>McCully Funeral Home of Pasadena<br/>3204 Mountain Rd., Pasadena, MD 21122</b>  |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic poorly differentiated carcinoma of lung.</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>L. F. Awaali, M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>200371</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/26/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>L. F. Awaali, M.D. 300 S. HANOVER ST. BALTO. MD 21230</b>  |  |  |  |  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26593

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>David Albert Thomas  |  |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 24 YEAR 90   |  | 3. TIME OF DEATH<br>7:00 p.m.  |  |
| 4. SOCIAL SECURITY NUMBER<br>217-44-0241   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>80 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>9/13/10   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Pennsylvania   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>2901 St. Paul Street   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City  |  |
| 10a. STATE<br>Maryland   |  |  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore City  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br>2901 St. Paul Street   |  | 10f. ZIP CODE<br>21218   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4 years  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Supervisor/Immigration   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Dept. of Justice   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>David John Thomas   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Edith Hopkins   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Kathryn M. Thomas  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2901 St. Paul Street, Baltimore, MD. 21218  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Green Mount Cemetery   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Maryland   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>John G. Reitz   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Mitchell-Wiedefeld Home<br>6500 York Rd., Baltimore, Maryland 21212  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PROSTATE CANCER<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br>12 YEARS |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Eric J. Seifter MD  |  |  |  | 29c. LICENSE NUMBER<br>D29373  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/25/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>ERIC J. SEIFTER 611 PARK AVE, BALTIMORE, MD 21201   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990   |  |  |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

© 2006 The Authors  
Journal compilation © 2006 Blackwell Publishing Ltd

1000

\_\_\_\_\_



90 26594

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Alvin J. Turner</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>21</b> YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>0941 a.m.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218 42 0795</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>42</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>02 07 1948</b>                                     |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>Univ. of Md Hospital</b>   |  |   |  | 9. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  | 10. COUNTY OF DEATH<br><b>Baltimore City</b>  |  |
| 11. RESIDENCE OF DECEDENT  |  |   |  | 12. CITY, TOWN OR LOCATION  |  | 13. INSIDE CITY LIMITS?   |  |
| 10a. STATE<br><b>md</b>  |  | 10b. COUNTY<br><b>Baltimore City</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>317 N. Stricker Street</b>  |  |   |  | 10f. ZIP CODE<br><b>21201</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>LANDSCAPER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HENRY TURNER</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LEONA COBB</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>LEONA TURNER</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>317 N. Stricker St Baltimore, MD</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT. CALVARY CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>BROOKLYN, MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Larry Harris</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Larry Harris F.A. 638 N. Gilmore St Baltimore, MD 21217</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b>   |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>Sepsis</b>   |  |   |  |   |  |   | 3wks   |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   | 3wks   |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Poor nutritional status</b>   |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br><b>9/21/90</b>   |  | 28b. TIME OF INJURY<br><b>941a.m.</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>Univ. Hospital</b>   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>225 Greene St.</b>   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Tamara S Sobel</b>   |  |   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/21/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>TAMARA S SOBEL 225 Greene St Baltimore 21201</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Jake Davidson-Randall</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Dino L. Taylor  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-25-90  |  | 3. TIME OF DEATH<br>4:50PM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>218-92-7669  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>23 YRS.  |  | 7. DATE OF BIRTH<br>MONTH DAY YEAR<br>12 20 66   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Intersection-Rutland & BarnesStreets   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City  |  |
| 9c. COUNTY OF DEATH   |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>1006 Caroline Street   |  |
| 10f. ZIP CODE   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)                            |  |
| 16a. DECECENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Laborer  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Lawrence Taylor  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Ruth Banks  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Ruth Davis  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1006 Caroline Street Baltimore, Maryland  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Baltimore Cemetery   |  | 20c. LOCATION — City or Town, State<br>Baltimore Maryland  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Derry Harris   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>1701 McCulloh St.<br>Chatman-Harris F/H Baltimore, Md  |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple gunshot wounds<br>s. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  | Approximate Interval Between Onset and Death                           |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>XX YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>XX YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Scene  |  |  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>9-25-90  |  | 28b. TIME OF INJURY<br>4:45PM  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br>Subject shot   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>Street   |  |  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>Rutland & Barnes Street at Intersection, Baltimore, MD  |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Mario F. Golle, Jr., MD  |  | 29c. LICENSE NUMBER<br>OCME  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-26-90   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARIO F. GOLLE, JR., MD 111 Penn Street, Baltimore, MD 21201   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26596

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |  |  |   |   |   |
|---|--|---|--|--|--|--|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>DUANE E. WINDER   |  |   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09-24-90                     |  | 3. TIME OF DEATH<br>M   |   |   |
| 4. SOCIAL SECURITY NUMBER<br>214-64-2275  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>34 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>1-24-56                  |  | 8. BIRTHPLACE (State or Foreign Country)<br>PA.   |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>2314 DRUIDHILL AVE.   |  |   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE, MD               |  | 9c. COUNTY OF DEATH   |   |   |
| RESIDENCE OF DECEDENT   |  |   |  |  |  |  |  |   |   |   |
| 10a. STATE<br>MD  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE, CITY   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |   |
| 10e. STREET AND NUMBER<br>2314 DRUIDHILL AVE.   |  |   |  | 10f. ZIP CODE<br>21217   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                               |  |   |   |   |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK |   |   |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th<br>College (1-4 or 5+)   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>UNEMPLOYED  |  |  | 16b. KIND OF BUSINESS/INDUSTRY                                   |   |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>CHARLES WINDER   |  |   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>GEORGIA HYATT |  |   |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>CHARLES WINDER III  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2504 BROOKFIELD AVE.-BALTIMORE, MD. 21217   |  |  |  |   |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>WESTERN STAR CEMETERY  |  |  | 20c. LOCATION — City or Town, State<br>CATONSVILLE, MD.          |   |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Darius Cord  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>WM.C. MARCH F.H. 1101 E. NORTH AVE.  |  |  |  |   |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Giant Cell Carcinoma<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |  |  |  |  |   | Approximate interval Between Onset and Death<br>2 months  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined   |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   | 28d. DESCRIBE HOW INJURY OCCURRED   |
|   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |   |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Brian Ranza MD   |  |   |  |  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/25/90  |   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Brian Ranza Johns Hopkins Hospital Tower 110   |  |   |  |  |  |  |  |   |   |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 28 1990  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |  |  |   |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26597

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GEORGE FREDERICK WOLF</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>25</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>9 05 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-07-9488A</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>May 31 1903</b>                                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Baltimore</b>  |  |  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Greater Laurel Beltzville Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Laurel, Maryland</b>  |  | 9c. COUNTY OF DEATH<br><b>Prince George</b>   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Md</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>2847 Louisiana Avenue</b>  |  |  |  | 10f. ZIP CODE<br><b>21227</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/><br><b>2 Years</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Plumber</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Carl Frederick Wolf</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lena (unknown)</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Raymond F. E. Wolf, Sr.</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>207 Hillendale Avenue, Baltimore, Md. 21227</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James E. Smith</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hubbard Funeral Home Inc.<br/>4107 Wilkens Avenue, Baltimore, MD. 21229</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Secondary</b><br>b. <b>Bilateral pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Coronary Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>Dehydration, Electrolyte Imbalance</b> |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
|   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>James E. Smith</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>SASue 24721</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/26/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26598

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Harry F. Wright</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 20 90</b>  |  | 3. TIME OF DEATH<br><b>11:30 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-10-2855</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>09-07-10 Md</b>   |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>Deer's Head Center</b>  |  |  |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>Salisbury</b>   |  | 9c. COUNTY OF DEATH<br><b>Wicomico</b>  |  |
| 10a. STATE<br><b>Md.</b>  |  |  |  | 10b. COUNTY<br><b>Wicomico</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Salsbury</b>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>1512 Riverside Drv.</b>  |  |   |  |
| 10f. ZIP CODE<br><b>21801</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 6+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Poultry</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Agriculture</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Albert Wright</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Annie Quillen</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charles Wright</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>RTE BOX 548, EDEN, MD 21822</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | 20c. LOCATION — City or Town, State   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board Balto. Md.</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>Renal failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Congestive Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Cerebral vascular accident</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>4 days</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Pending Investigation<br>3 <input type="checkbox"/> Accident 4 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>D33905</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/21/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Virginia D Slacum, M.D. P.O.Box 2018 Salisbury, Md. 21801</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 28 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first

page of the

document

contains

the following

information

which is

contained

in the

document

and

is the same as the information

90 26599

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |  |   |
|---|--|--|--|---|--|--|---|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Rose Zajac</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>25</b> YEAR <b>90</b>   |  |  |   | 3. TIME OF DEATH<br><b>12:25p</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>213-18-2448</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>93 YRS.</b> | IF UNDER 1 YEAR<br>MONTHS<br><b>93</b>  | IF UNDER 24 HRS.<br>HOURS<br><b>93</b>                       | MIN.<br><b>93</b>  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>10-05-1896</b>                                     |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>POLAND</b> |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>FRANCIS SCOTT KEY MED. CEN.</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  |  | 9c. COUNTY OF DEATH   |  |   |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |   |  |   |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |   |
| 10e. STREET AND NUMBER<br><b>6713 1/2 BOSTON AVENUE</b>   |  |  |  | 10f. ZIP CODE<br><b>21222</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                      |   |  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                      |  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>            |  |   | 16b. KIND OF BUSINESS/INDUSTRY                               |  |   |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JACOB MANIECKI</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>AGNES HANKUS</b>  |  |  |   |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MR. CASIMIR ZAJAC</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6713 1/2 BOSTON AVE. BALTO. MD. 21224</b>   |  |  |   |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>HOLY ROSARY CEMETERY</b>  |  |   | 20c. LOCATION — City or Town, State<br><b>BALTO. CO. MD.</b> |  |   |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles R. Kaczorowski</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>KACZOROWSKI FUNERAL HOME<br/>2525 FLEET ST. BALTO. MD. 21224</b>   |  |  |   |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  |   | Approximate Interval Between Onset and Death<br><b>2 days</b><br><b>5 mos</b><br><b>years</b>  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Breast Cancer</b>  |  |  |  |   |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED  |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                      |  |  |  |   |  |  |   |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Ann Fitzgerald MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D40394</b>  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/25/90</b>   |  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Ann Fitzgerald MD, 4940 Eastern Ave., Baltimore MD 21224</b>  |  |  |  |   |  |  |   |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>9/28/1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |   |  |  |   |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 90-26600

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RICHARD N. ALLEN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPT 16 1990</b>   |  | 3. TIME OF DEATH<br>HOURS MIN.<br><b>6:55 A</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>036-18-1406</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>3/1/1920</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MONTGOMERY GENERAL HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>OLNEY</b>   |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Spencerville</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>2020 Spencerville Road</b>  |  |  |  | 10f. ZIP CODE<br><b>20868</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1-12</b><br>College (1-4 or 5+) <b>C.P.A.</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>US Government</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>US Government</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Arthur John Allen</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Margaret Johnson</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Bernice P. Allen</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2020 Spencerville Road, Spencerville, Md.</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Alexandria, Va.</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael Rinaldi</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hines/Rinaldi Funeral Home</b><br><b>11800 N.H. Ave., Silver Spring, Md. 20904</b>  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Gastrointestinal Bleeding</b>   |  |  |  |   |  |  |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |  |  |
| a. <b>Cirrhosis of the Liver</b>   |  |  |  |   |  |  |  |
| b. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>   |  |  |  |   |  |  |  |
| c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>   |  |  |  |   |  |  |  |
| d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>HOURS MIN.<br><b>1 00</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
|  |  |  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Barry Hecht, MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D19192</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>September 16, 1990</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Barry Hecht 3941 FERRARA DRIVE WHEATON, MD 20906</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 17 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



90 26601

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LEROY C. BEST</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>8</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>2202</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>032-28-4199</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>52</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8-12-38</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ANNE ARUNDEL HOSP</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ANNAPOLIS</b>  |  | 9c. COUNTY OF DEATH<br><b>AA</b>  |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>SILVER SPRING</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                  |  |
| 10e. STREET AND NUMBER<br><b>1115 NOVEMBER CIRCLE</b>   |  |  |  | 10f. ZIP CODE<br><b>20904</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                                |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>SALES MANAGER</b>               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>CALDWELL BANKER</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>LEROY BEST</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>RUBY KNIGHT</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>EVA BEST</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>260 MUNSON ST. NEW HAVEN, CONN. 06511</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BEAVERDALE MEM. PARK</b>  |  | 20c. LOCATION — City or Town, State<br><b>NEWHAVEN, CONN.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Harry J. Reese</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>821 WEST ST. ANNAPOLIS, MD. 21401</b><br><b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Myocardial Infarction</b>  |  |  |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>ASCVD</b>   |  |  |  |  |  |   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>William P. Jones Deputy</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>DD06054</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/9/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>William P. Jones 695 America 21055</b>  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 12 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text at the bottom of the page, possibly a signature or date.



90 26602

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>William R. Blessing</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>9-12-90</i>  |  | 3. TIME OF DEATH<br><i>0134 A.M.</i>   |   |
| 4. SOCIAL SECURITY NUMBER<br><i>21814 3786</i>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>45</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>6-9-25</i>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Pennsylvania</i>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Anne Arundel Medical Center</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Annapolis</i>  |   |
| 9c. COUNTY OF DEATH<br><i>Anne Arundel</i>   |  |  |  | 10a. STATE<br><i>MD</i>   |  | 10b. COUNTY<br><i>Anne Arundel</i>   |   |
| 10c. CITY, TOWN OR LOCATION<br><i>Annapolis</i>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><i>113 Edgemere Drive</i>  |   |
| 10f. ZIP CODE<br><i>21403</i>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>W W II</i>  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>11</i> College (1-4 or 5+) <i></i>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Trouble Shooter</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Baltimore Gas &amp; Electric Company</i>  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Oliver Blessing</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Mildred ----</i>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>June B. Blessing</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>113 Edgemere Drive, Annapolis, MD 21403</i>   |  |  |   |
| 20. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Hillcrest Cemetery</i>   |  | 20c. LOCATION — City or Town, State<br><i>Annapolis, MD</i>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Donald S. Lyth</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Taylor Funeral Chapel 21401<br/>147 Gloucester St., Annapolis, MD</i>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac Arrest</i>  |  |  |  |   |  |  |   |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |  |   |
| DUE TO (OR AS A CONSEQUENCE OF): <i>Systemic embolysis</i>   |  |  |  |   |  |  |   |
| DUE TO (OR AS A CONSEQUENCE OF): <i>Arterial fibrillation; Cardiomyopathy</i>  |  |  |  |   |  |  |   |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Polycystic Hemorrhagic Vena</i>   |  |  |  |   |  |  |   |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robert M. Greenfield M.D.</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>A 26373</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9/16/90</i>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Robert M. Greenfield M.D. 139 Old Solomon Rd</i>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><i>SEP 13 1990</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Robert</i>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.



90 26603

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Robert Lee Bradford  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-4-90   |  | 3. TIME OF DEATH<br>2:56 p. m.   |  |
| 4. SOCIAL SECURITY NUMBER<br>225-56-6884   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>47 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>09-20-1942  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Florida  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Edw. W. McCready Mem. Hospital   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Crisfield   |  |
| 9c. COUNTY OF DEATH<br>Somerset  |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Somerset  |  |
| 10c. CITY, TOWN OR LOCATION<br>Crisfield   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>Rt. 1 - Box 142 C - Hopewell   |  |
| 10f. ZIP CODE<br>21817   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>Vietnam War   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (14 or 5+)<br>H. S. Graduate - - -  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Correctional Guard   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>E C I<br>State of Maryland   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Robert H. Bradford  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Kathryn Sleight   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mary Jane Bradford   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same as 10 a,b,c,d,e,f  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)<br>09-07-90  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Sunnyridge Memorial Park   |  | 20c. LOCATION — City or Town, State<br>Crisfield, MD   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert H. Bradshaw, Jr.</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Bradshaw & Sons, Main St., Crisfield, Md.<br>21817   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Myocardial infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
|  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>M. D. Barhan</i>   |  |  |  | 29c. LICENSE NUMBER<br>12764   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/5/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. M. D. Barhan, Rt. #413, Crisfield, Md. 21817  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 10 '90  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10725 ne

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |                          |  |   |  |  |
|--|--|--|--|---|--------------------------|--|---|--|--|
| CERTIFICATE OF DEATH   |  |  |  |   |                          |  |   |  |  |
| REG. NO.   |  |  |  |   |                          |  |   |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARJORIE H. BARGERON</b>  |  |  |  |   |                          | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 - 08 - 90</b>  |   | 3. TIME OF DEATH<br><b>9:25 A M</b>                    |  |
| 4. SOCIAL SECURITY NUMBER<br><b>259-32-0423</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS  |                          | IF UNDER 24 HRS.<br>HOURS MIN.   |   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>07-19-06</b> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SALISBURY NURSING HOME</b>  |  |  |  |   |                          | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SALISBURY</b>  |   | 9c. COUNTY OF DEATH<br><b>WICOMICO</b>                 |  |
| 10a. STATE<br><b>MD</b>  |  |  |  |   |                          | 10b. COUNTY<br><b>Somerset</b>   |   | 10c. CITY, TOWN OR LOCATION<br><b>Crisfield</b>        |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |                          |  |   |  |  |
| 10e. STREET AND NUMBER<br><b>Rt. 2 - Box 49 - Jacksonville Road</b>  |  |  |  |   |                          | 10f. ZIP CODE<br><b>21817</b>  |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>            |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                          |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grade 10</b><br>College (1-4 or 5+) <b>--</b>  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |   |                          | 16b. KIND OF BUSINESS/INDUSTRY<br><b>At Home</b>   |   |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Robert Andrew Holloway</b>   |  |  |  |   |                          | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mamie Oxford</b>   |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Levon D. Bargerone</b>  |  |  |  |   |                          | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as # 10 a b c d e f g</b> |   |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Antioch Cemetery</b>  |   |                          | 20c. LOCATION — City or Town, State<br><b>Twin City, Georgia</b>   |   |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert B. Bargerone</i>  |  |  |  |   |                          | 22. NAME AND ADDRESS OF FACILITY<br><b>Bradshaw &amp; Sons Funeral Home<br/>306 W. Main St. - Crisfield, MD 21817</b>              |   |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebrovascular accident</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF): <b>ASCVD</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><br>Approximate Interval Between Onset and Death<br><b>3 mos</b> |  |  |  |   |                          |  |   |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                          |  |   |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |   | 28d. DESCRIBE HOW INJURY OCCURRED                      |  |
|  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   |                          | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |                          |  |   |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>C. Hagan MD</i>  |  |  |  |   |                          | 29c. LICENSE NUMBER<br><b>D25219</b>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-8-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CHARLES STEGMAN, MD RT. 50 &amp; CIVIC AVE., SALISBURY, MD 21801</b>   |  |  |  |   |                          |  |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 11 '90</b>   |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randell</i>   |   |                          |  |   |  |  |

ECON-07-RCG

novel • 101

90 26605

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Hazel Josephine BEACHLEY</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>19</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>0450 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-40-2748B</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>May 15, 1903</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |
| 10a. STATE<br><b>Maryland</b>  |  |   |  | 10b. COUNTY<br><b>Frederick</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Middletown</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>6605 Burkittsville Rd.</b>   |  |   |  |
| 10f. ZIP CODE<br><b>21769</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Nunamaker</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Clara Reeder</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John Claude Beachley</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6605 Burkittsville Rd., Middletown, Md. 21769</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Boonsboro Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Boonsboro, Md. 21713</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>John H. Bast, Jr.</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>7606 Boonsboro Pike<br/>BAST FUNERAL HOME, Boonsboro, Md. 21713</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Heart Disease - Atrial Fibrillation</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b></b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b></b><br>Approximate Interval Between Onset and Death<br><b>Immed</b><br><b>over 7 yrs</b> |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO             |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |   |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                      |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>James A. Friezell, M.D.</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>D16637</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/19/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>James A. Friezell, M.D., 215 Tollhouse Ave, Frederick, Md 21701</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 21 90</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John H. Bast, Jr.</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 7 and 8 may be retained by the funeral director. Page 5 should be detached for use as the burial-transit permit. Pages 9 and 10 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

96

RECEIVED

1957



90 26606

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Margaret S. Barnett</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 19 90</b>   |  | 3. TIME OF DEATH<br><b>10:17 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-20-0351</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 29, 1901</b>                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Md.</b>   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Avalon Manor Home</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>                     |  |
| 9c. COUNTY OF DEATH<br><b>Washington</b>   |  |   |  | 10a. STATE<br><b>Md.</b>  |  |  |  |
| 10b. COUNTY<br><b>Washington</b>   |  |   |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>  |  |  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>402 Park Place</b>   |  |  |  |
| 10f. ZIP CODE<br><b>21740</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Elementary</b><br>College (1-4 or 5+) <b>College</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Benjamin Barnett</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ada Blake</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Madeline Adams</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Potomac Towers, Apt. 724, Hagerstown, Md. 21740</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greenlawn Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Williamsport, Md.</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Dennis L. Davis</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Watson Funeral Home, 24 W. Bethel St.</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Metastatic Carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Carcinoma of prostate</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Arteriosclerotic hypertensive Cardio-vascular disease</b>   |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John N. Fander M.D.</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>D04262</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>20 Sept. 1990</b>                  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John N. Fander M.D., 138 E. Antietam St. Hagerstown, MD 21740</b>  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 20 '90</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26607

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Lloyd Morris Bentzel</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>19</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>10:55 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-32-5413</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>87 89</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 21, 1900</b>                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Avalon Manor Nur. Home</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>  |  | 9c. COUNTY OF DEATH<br><b>Washington</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Washington</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>321 South Mulberry Street</b>  |  |   |  |
| 10f. ZIP CODE<br><b>21740</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5</b><br>College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Owner - Operator</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Beer Distributor</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John H. Bentzel</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Emma E. Eyler</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Anna C. Bentzel</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>321 South Mulberry St., Hagerstown, Md. 21740</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Weller's U.M. Church Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Thurmont., Frederick, CO. Md</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>R. Hall Bundy</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Andrew K. Coffman Funeral Home, Inc.<br/>40 E. Antietam St., Hagerstown, Md. 21740</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Respiratory Insufficiency / Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Pneumonia / Alzheimer's Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Approximate Interval Between Onset and Death |  |  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Multiple CVA, 2 Anterior Circulate Cerebro-vascular Disease - Diffuse Cerebral Atrophy</b><br><b>Urinary Tract Infection</b>   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D 04262</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>20 Sept. 1990</b>                                 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Wm H. Fender MD 138 E Antietam St Hagerstown, MD 21740</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 21 90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26608

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mary Ellen BENNETT   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 20, 1990  |  | 3. TIME OF DEATH<br>3:45 A M  |   |
| 4. SOCIAL SECURITY NUMBER<br>217 10 2641   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>75 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>2/20/15   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Washington County Hospital   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown   |  | 9c. COUNTY OF DEATH<br>Washington   |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Washington  |  | 10c. CITY, TOWN OR LOCATION<br>Hagerstown   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>520 Summit Ave.  |  |  |  | 10f. ZIP CODE<br>21740  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 yrs.<br>College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>homemaker   |  | 16b. KING OF BUSINESS/INDUSTRY<br>home  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Lewis H. Blair  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Orpha Viola Davis  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Beverly D. Smith   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>14969 Wingerton Rd. Waynesboro, Penna. 17269   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Rest Haven Cemetery  |  | 20c. LOCATION — City or Town, State<br>Hagerstown, Md.  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Gerald N. Minnich</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Gerald N. Minnich 305 N. Potomac St.<br>Funeral Home Hagerstown, Maryland   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Squamous Cell Carcinoma of Right Lung   |  |  |  |   |  |   | 6-8 month   |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |   |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |   |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |   |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |   |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |   |
|  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Edward W. Ditto, III</i>   |  |  |  | 29c. LICENSE NUMBER<br>D01062   |  | 29d. DATE SIGNED (Month, Day, Year)<br>Sept. 21, 1990   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Edward W. Ditto, III, M.D., 217 West Washington Street, Hagerstown, Maryland 21740  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 24 '90  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

Really (to be)

Handwritten signature

12-5-15

90 26609

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Nellie Kathryn Boward</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 23 90</b>   |  | 3. TIME OF DEATH<br><b>1:55 am</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-09-0864</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>95</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10-11-94</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Hagerstown Nursing Home</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>  |  | 9c. COUNTY OF DEATH<br><b>Washington</b>  |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Washington</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>115. Walnut St Apt 209</b>  |  |  |  | 10f. ZIP CODE<br><b>21740</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                        |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (8-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>House</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William H. French</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Christianna Kline</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charlene Bragunier</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12315 Countryview Dr. Clear Spring Md 21732</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rest Haven Cem.</b>   |  | 20c. LOCATION — City or Town, State<br><b>Hagerstown Md.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Edson B. Moody</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Thompson Funeral Home Inc.<br/>PO Box 310 Clear Spring MD 21732</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |   |  |   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |  |
| a. <b>Bronchopneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Uncontrolled Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Arteriosclerotic Heart Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic arteriosclerosis with stenosis</b>  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO              |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                      |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Edson B. Moody</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>DC7857</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/24/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>EDSON B. MOODY 1190 Mt. Aetna Rd. HAGERSTOWN MD 21740</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 25 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julie Davidson-Randall</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26610

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LOGHMAN BAHRAMYAR</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 7, 1990</b>  |  | 3. TIME OF DEATH<br><b>10:50 A.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-06-5435</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>3/21/1909</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Suburban Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bethesda</b>  |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>2301 Ring Street</b>   |  |  |  | 10f. ZIP CODE<br><b>20851</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>Iran</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Merchant</b>                    |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Rugs</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Shalom Khalepari</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Khanoom Khalepari</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Akhtar Bahramyar (wife)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2301 Ring Street, Rockville, MD 20851</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Lebanon Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Adelphi, Maryland</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Danzansky-Goldberg Memorial Chapels, Inc.<br/>1170 Rockville Pike, Rockville, MD 20852</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>Carcinoma (R)lung with metastases</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Renal failure</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Renal failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Renal failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Renal failure</b> |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>7 weeks</b><br><b>1 day</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> MD  |  |  |  | 29c. LICENSE NUMBER<br><b>D20065</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Sept. 7, 1990</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>EVA MORELL 6000 EXECUTIVE BLVD, ROCKVILLE, MD 20852</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 13 '90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26611

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mary Annette Bowens</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>11</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>1025</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-46-6461</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>68</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>08-11-22</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  |   |  | 10b. COUNTY<br><b>Frederick</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>132 W. All Saints Street</b>   |  |   |  | 10f. ZIP CODE<br><b>21701</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b><br>College (14 or 8+) <b>Cook</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Cook</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Hood College</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Greenberry Holsey</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Gertrude Snowden</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Roger W. Bowens (Husband)</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>132 W. All Saints St., Frederick, MD 21701</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Friendship Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Damascus, MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>George R. Snowden</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Snowden Funeral Home, P.A.<br/>Rockville, MD 20850</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Extensive breast cancer</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  | Approximate interval between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|   |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 25. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br>3 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>014626</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/11/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 14 '90</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rodell</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1187 - 67

90 26612

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MEDORESE M. BORG</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPT. 14, 1990</b>  |  | 3. TIME OF DEATH<br><b>5:00 A. M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>387-12-6537</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>FEB. 6, 1920</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>WISCONSIN</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>1438 CASINO CIRCLE</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SILVER SPRING</b>  |  |
| 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |  |  | 10a. STATE<br><b>WASHINGTON, D.C.</b>  |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>2400 VIRGINIA AVENUE, N.W., #C1115</b>  |  |
| 10f. ZIP CODE<br><b>20037</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (13-16) <b>4</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>ACCOUNTANT</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>WEAVER BROTHERS</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>CHARLES N. MULIKEN</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LAURA KEITH VANDERLYN</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>RICHARD JANSON (SON)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11029 CEDAR LANE, BELTSVILLE, MARYLAND 20705</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GATE OF HEAVEN CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>SILVER SPRING, MARYLAND</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Andrew J. Cole</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W., SIL. SP., MD 20901</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hepatic Encephalopathy</b>  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>Liver Metastases</b>   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>Pancreatic Cancer</b>  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| Approximate Interval Between Onset and Death<br><b>5 days</b>  |  |  |  |  |  |  |  |
| Approximate Interval Between Onset and Death<br><b>5 months</b>  |  |  |  |  |  |  |  |
| Approximate Interval Between Onset and Death<br><b>5 months</b>  |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John B. Fox MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>18126 (DC)</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/17/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Henry B Fox MD, 730 24th St NW, Washington DC</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 17 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

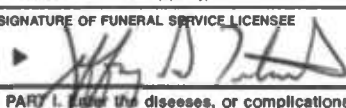
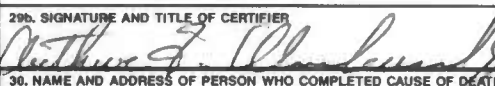
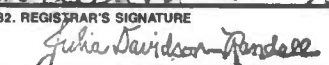
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26613

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |  |                                   |   |  |
|--|--|--|--|--|--|---|--|--|-----------------------------------|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Stella Becquet   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>September 13, 1990   |  |   |  | 3. TIME OF DEATH<br>11:13 PM   |                                   |   |  |
| 4. SOCIAL SECURITY NUMBER<br>196 22 9358   |  |  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>78 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>June 21, 1912                              |                                   | 8. BIRTHPLACE (State or Foreign Country)<br>Ukraine   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Montgomery General Hospital  |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Olney  |  |  | 9c. COUNTY OF DEATH<br>Montgomery |   |  |
| 10a. STATE<br>Pennsylvania   |  |  |  | 10b. COUNTY<br>Cambria   |  | 10c. CITY, TOWN OR LOCATION<br>Johnstown  |  |  |                                   | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>604 Wood Street  |  |  |  | 10f. ZIP CODE<br>15902   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States                                       |                                   |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |                                   |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6 College (1-4 or 5+) -  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Cook  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Hospital   |                                   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Frank Bizak   |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Annie Perok  |  |  |                                   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Rochelle Y. Conrad   |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13422 Tangier Place, Rockville, Maryland 20853 |  |  |                                   |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>St. Mary's Cemetery  |  |   |  | 20c. LOCATION — City or Town, State<br>Ramey, Pennsylvania                           |                                   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br> M00689   |  |  |  | 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Md. 20814-3501  |  |   |  |  |                                   |   |  |
| 23. PART I. List the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiopulmonary Arrest</u><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <u>Peritonitis</u><br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Widely Metastatic GI Cancer</u><br><u>Left coronal CVA</u> |  |  |  |  |  |   |  |  |                                   | Approximate Interval Between Onset and Death  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |                                   |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                   | 28d. DESCRIBE HOW INJURY OCCURED  |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br> MD                 |  | 29c. LICENSE NUMBER<br>D24190  |                                   | 29d. DATE SIGNED (Month, Day, Year)<br>9/14/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>ARTHUR F Woodward JR, 3111 Prince Philip Dr Olney MD #526   |  |  |  |  |  |   |  |  |                                   |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 17 '90  |  |  |  | 32. REGISTRAR'S SIGNATURE<br> 20852   |  |   |  |  |                                   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-0146  
 TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26614

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Thomas L. Barnette   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09-05-90  |  | 3. TIME OF DEATH<br>1115 M  |   |
| 4. SOCIAL SECURITY NUMBER<br>215-44-7201   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br>44 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>11-02-45   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Peninsula General Hospital   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Salisbury  |  | 9c. COUNTY OF DEATH<br>Wicomico   |   |
| 10a. STATE<br>Maryland   |  |  |  | 10b. COUNTY<br>Somerset   |  | 10c. CITY, TOWN OR LOCATION<br>Princess Anne  |   |
| 10e. STREET AND NUMBER<br>Route 1 Mt. Vernon Rd.   |  |  |  | 10f. ZIP CODE<br>21853  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) College   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Commerical Diver                   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>John T. Barnette  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Sarah Huffman  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Patricia Anne Barnette   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Rt. 1, Box 223 A, Princess Anne, Md. 21853   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Grace Episcopal Cemetery   |  | 20c. LOCATION — City or Town, State, Zip Code<br>Princess Anne, Md.   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James L. Hinman</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Hinman Funeral Home<br>127 Somerset Ave., Princess Anne, Md.  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple Trauma<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Tractor Accident<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>09-05-90   |  | 28b. TIME OF INJURY<br>0900 M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>Pinned under tractor  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>Box 237, Princess Anne, Md.   |  |   |   |
|  |  | 28f. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>Farm - Black Rd., - Rt. 1                              |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John T. Bulkeley</i> Deputy M.E.   |  |  |  | 29c. LICENSE NUMBER<br>D03599   |  | 29d. DATE SIGNED (Month, Day, Year)<br>09-05-90   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>John T. Bulkeley, M.D., 108 Pine Bluff Rd., Salisbury, Md.  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP - 7 '90   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

55 75

7. *Conclusions*

every day. I said to him,

C 1

2000 年 12 月 10 日

$\frac{7}{8} \times 10 = 8\frac{1}{2}$

• 5 •

90 26615

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |                             |  |  |   |  |  |  |   |  |  |  |
|--|--|--|-----------------------------|--|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>GEORGE CLARK JR.   |  |  |                             | 2. DATE OF DEATH<br>SEPTEMBER 3, 1990  |  |   |  | 3. TIME OF DEATH<br>12:37P   |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>218-04-7827   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |                             | 8. AGE (In yrs. last birthday)<br>6 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Jan 5 1984                   |  | 6. BIRTHPLACE (State or Foreign Country)<br>MARYLAND |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL   |  |  |                             |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  |  |  | 9c. COUNTY OF DEATH<br>BALTIMORE CITY                               |  |  |  |
| RESIDENCE OF DECEDENT  |  |  |                             |  |  |   |  |  |  |   |  |  |  |
| 10a. STATE<br>MARYLAND   |  |  | 10b. COUNTY<br>ANNE ARUNDEL |  |  | 10c. CITY, TOWN OR LOCATION<br>PASADENA   |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   |  |  |  |
| 10e. STREET AND NUMBER<br>7845 COUTROCUS COURT   |  |  |                             |  |  | 10f. ZIP CODE<br>21122  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |  |  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |                             |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>BLACK |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)   |  |  |                             | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>GEORGE CLARK, Sr.   |  |  |                             |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>KATHY BUTLER   |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>KATHY BUTLER   |  |  |                             |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7845 COUTROUCUS CT. PASADENA, MARYLAND   |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |                             | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>PINELAWN MEM. PARK   |  |   |  | 20c. LOCATION — City or Town, State<br>ANNAPOLIS, MD.                            |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Larry H. Reese</i>   |  |  |                             |  |  | 22. NAME AND ADDRESS OF FACILITY<br>821 WEST ST. ANNAPOLIS, MD. 21401<br>WILLIAM REESE & SONS MORTUARY, P.A.  |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |                             |  |  |   |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |                             |  |  |   |  |  |  | Approximate Interval Between Onset and Death                        |  |  |  |
| a. Status Epilepticus  |  |  |                             |  |  |   |  |  |  | 5 days  |  |  |  |
| b. Seizure Disorder  |  |  |                             |  |  |   |  |  |  | 5 yrs   |  |  |  |
| c. Cardiopulmonary Arrest  |  |  |                             |  |  |   |  |  |  | 5 yrs   |  |  |  |
| d. Congenital Heart Disease  |  |  |                             |  |  |   |  |  |  | 6 yrs   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |                             |  |  |   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |                             |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |                             | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |                             | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                                   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |                             | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>George E. Hardart MD.</i>  |  |   |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/3/90                       |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>GEORGE HARDART 600 N. White Street Baltimore, MD 21205  |  |  |                             |  |  |   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 12 1990   |  |  |                             | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 7 and 8 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 7 and 8 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26616

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br>Frances I Christopher  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09 12 90  |  | 3. TIME OF DEATH<br>0647A M  |  |
| 4. SOCIAL SECURITY NUMBER<br>217 14 9214   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>67 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>03 26 23  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Baltimore, MD  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>North Arundel Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Glen Burnie, MD   |  |
| 9c. COUNTY OF DEATH<br>Anne Arundel  |  |   |  | 10a. STATE<br>MD  |  | 10b. COUNTY<br>Anne Arundel  |  |
| 10c. CITY, TOWN OR LOCATION<br>Odenton   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>1439 Odenton Road  |  |
| 10f. ZIP CODE<br>21113   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |   |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1  |  |   |  | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Administrative Assit.   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Accounting   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Henry Talbot  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mildred E. Sponsler  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Sandy Keeney   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1372 Odenton Road, Odenton, MD 21113   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Metro Crematory   |  | 20c. LOCATION — City or Town, State<br>Baltimore, MD   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Beth J. Smith</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Hardesty Funeral Home P.A.<br>851 Annapolis Road, Gambrills, MD   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Myocardial Infarction</i><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <i>Due to (OR AS A CONSEQUENCE OF):</i> <i>Chronic Ischemic Cardiovascular Disease</i><br>b. <i>Due to (OR AS A CONSEQUENCE OF):</i> <i>Coronary Heart Failure</i><br>c. <i>Due to (OR AS A CONSEQUENCE OF):</i><br>d. |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Chronic Obstructive Pulmonary Disease</i>   |  |   |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Chackumkal V Cyriac</i> Attending Doctor   |  |   |  | 29c. LICENSE NUMBER<br>D21684   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/12/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Chackumkal V Cyriac 1600 Crain Hwy, SW #308 Glen Burnie, MD 21061   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 13 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 26617

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LOUISE P. CAVANAUGH</b>   |  |   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>10</b> YEAR <b>90</b>                     |  | 3. TIME OF DEATH<br><b>630 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220 03 8034</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Apr. 1, 1921</b>                           |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b>   |  |   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Annapolis</b>                              |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>   |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |  |  |  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Anne Arundel</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Annapolis</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>95 Conduit Street</b>   |  |   |  | 10f. ZIP CODE<br><b>21401</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1943 - 1970</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>           |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>3</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Nurse</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Navy</b>                                   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Louis Pollock</b>  |  |   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sarah Young</b>              |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Harrison A. Pollock</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>184 Acton Road, Annapolis, MD 21403</b>   |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arlington National Cemetery</b>  |  |   |  | 20c. LOCATION — City or Town, State<br><b>Arlington, VA</b>                          |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Jeffrey S. Taylor</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Taylor Funeral Chapel 21401<br/>147 Gloucester St., Annapolis, MD</b>  |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Metastatic Colon Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |  |  | Approximate interval Between Onset and Death<br><b>2 years ago</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>   |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
|  |  |   |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |  |  |
| 29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>E. W. Cole III</i>   |  |   |  |   |  | 29c. LICENSE NUMBER<br><b>D16354</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/10/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>E. W. COLE III 51 FRANKLIN ST ANNAPOLIS Md 21401</b>   |  |   |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year) <b>SEP 13 1990</b> 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |  |   |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

21712-100000



90 26618

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Dorothy Jane Chase</i>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>09 06 90</i>   |  | 3. TIME OF DEATH<br><i>5:53 p.m.</i>   |   |
| 4. SOCIAL SECURITY NUMBER<br><i>218-30-4481</i>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>85</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>9-30-04</i>                             |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Southern Maryland Hospital</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Clinton</i>                                |   |
| 9c. COUNTY OF DEATH<br><i>Prince Georges</i>   |  |   |  | 10a. STATE<br><i>Maryland</i>   |  | 10b. COUNTY<br><i>Charles</i>  |   |
| 10c. CITY, TOWN OR LOCATION<br><i>Waldorf</i>  |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><i>Box 209 Mattawoman Beantown Rd</i>                      |   |
| 10f. ZIP CODE<br><i>20601</i>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 10h. RACE — American Indian, Black, White, etc.<br>Specify: <i>Black</i>             |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>Black</i>              |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>8th</i> College (1-4 or 5+) <i>n/a</i>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Homemaker</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Domestic</i>   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Vincent</i>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Luisa Stewart</i>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Helen V. Chase</i>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>Box 209 Mattawoman Beantown Rd Waldorf Md.</i>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>St. Peters Ch. Cem</i>   |  | 20c. LOCATION — City or Town, State<br><i>Waldorf, Maryland</i>   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Shastell Adams</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Aguasca Road, Aguasca, Md. 20608</i>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |  | Approximate interval Between Onset and Death  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Myocardial Failure</i>   |  |   |  |   |  |  | <i>48 hr</i>  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Congestive Heart Failure</i>   |  |   |  |   |  |  | <i>3 wks</i>  |
| c. _____ DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |  |   |
| d. _____ DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Azotemia</i><br><i>Hyperkalemia</i>   |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
|  |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>T. L. Fieldson M.D.</i>   |  | 29c. LICENSE NUMBER<br><i>D01923</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>7 Sept 1990</i>                            |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>T. L. Fieldson M.D. BRANDYWINE, MD 20613</i>   |  |   |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><i>SEP 13 '90</i>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26619

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>James O. Cooksey</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>9</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>145 P</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216 44-7038</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>March 22, 1913</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Baltimore</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Physicians Memorial Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>La Plata</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Charles</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Charles</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Indian Head</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>46 Mattingly Avenue</b>   |  |
| 10f. ZIP CODE<br><b>20640</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>10</b> College (1-4 or 5+) <b></b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>U.S. Government</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas Vivvan Cooksey</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lucy Janette Murphy</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ruth Marie Cooksey</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>46 Mattingly Avenue Indian Head, Maryland 20640</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Charles Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Indian Head, Md.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Wesley Williams</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Williams Funeral Home, Inc.<br/>Rt. 225 and Glymont Rd. Indian Head, Md.</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerotic Cardiovascular Disease</b><br>Approximate interval Between Onset and Death <b>-years</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
|  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>HM Haft MD Chas Co. Deputy ME</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D27348</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/10/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Haft 3956 Tamarack Ct Walkers Md 20601</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 13 90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10-20-11

90 26620

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |                                |   |   |
|--|--|--|--|---|--------------------------------|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>George Tommy Coyle</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept 19 1990</b>   |                                | 3. TIME OF DEATH<br><b>4:30 p.m.</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>223-22-7652</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>JULY 6, 1920</b>                                   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>HIGHFIELD, MD</b>   |  |  |  |   |                                |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>WASHINGTON COUNTY HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>HAGERSTOWN</b>  |                                | 9c. COUNTY OF DEATH<br><b>WASHINGTON</b>  |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |                                |   |   |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>WASHINGTON</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>HIGHFIELD</b>   |                                | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>14730 HARBAUGH ROAD</b>   |  |  |  | 10f. ZIP CODE<br><b>21753</b>   |                                | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWI</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                      |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>8th</b>  |  | College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>LABORER</b>   |                                | 16b. KIND OF BUSINESS/INDUSTRY<br><b>MUNICIPAL WATER AUTHORITY</b>                              |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JAMES D. COYLE, SR.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>BERTHA F. BOWMAN</b>  |                                |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MRS. DOROTHY V. COYLE</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. BOX 1073, CASCADE, MD 21719</b>  |                                |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BETHEL CHURCH CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>CASCADE, MD</b>   |                                |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James G. Badenas</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>GROVE FUNERAL HOME</b><br><b>50 S. BROAD ST. WAYNESBORO, PA 17268</b>  |                                |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <b>Acute myelomonocytic Leukemia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |                                |   | Approximate interval Between Onset and Death<br><b>2 years</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Obstructive pulmonary disease</b>   |  |  |  |   |                                |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
|  |  |  |  |   |                                |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |                                |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 8 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 9 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 10 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |                                | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |                                |   |   |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |                                |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |                                |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Robert Brull Personal physician</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>104359</b>  |                                | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/20/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Robert Brull 1459 Potomac Ave. Hagerstown</b>  |  |  |  |   |                                |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 20 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |                                |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26621

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>THOMAS TYNDALL COFFIN   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>September 19, 1990  |  | 3. TIME OF DEATH<br>10:00 A.M.  |  |
| 4. SOCIAL SECURITY NUMBER<br>265-03-9449  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>77 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>January 31, 1913  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Washington County Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown   |  |
| 9c. COUNTY OF DEATH<br>Washington   |  |  |  | 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Washington   |  |
| 10c. CITY, TOWN OR LOCATION<br>Hagerstown   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>1302 Cedarwood Drive  |  |
| 10f. ZIP CODE<br>21740  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW II |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2                                |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Manager  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Restaurant  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Cornelius Coffin   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Virginia Smith   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Patty R. Coffin   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1302 Cedarwood Drive, Hagerstown, Md. 21740  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Smithsburg Crematorium  |  | 20c. LOCATION — City or Town, State<br>Smithsburg, Wash., Md.   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>L. Neil Brady  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Andrew K. Coffman Funeral Home, Inc.<br>40 E. Antietam St., Hagerstown, Md. 21740   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Large cell carcinoma of lung<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br>6 mo.  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Bilateral pneumonia<br>arteriosclerotic heart disease with congestive heart failure   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined |  |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Charles P. Spencer MD  |  | 29c. LICENSE NUMBER<br>D11133   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br>Sept 19, 1990  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Charles P. Spencer 1198 Kenly Ave Hagerstown Md.   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 21 '90   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John D. Anderson   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

and the number of days

93



90 26622

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Hazel Victoria COLBERT  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>September 19, 1990  |  | 3. TIME OF DEATH<br>6:00 a.m.  |   |
| 4. SOCIAL SECURITY NUMBER<br>213-24-9779  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>85 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Sept. 19, 1905   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>56 Delwood Avenue   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown  |   |
| 9c. COUNTY OF DEATH<br>Washington   |  |   |  | 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Washington  |   |
| 10c. CITY, TOWN OR LOCATION<br>Hagerstown   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>56 Delwood Avenue  |   |
| 10f. ZIP CODE<br>21740  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) ---   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>housewife  |  | 16b. KIND OF BUSINESS/INDUSTRY   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>David W. Reed  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Myrtle Hull  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Ernest T. Rice  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>56 Delwood Ave., Hagerstown, Maryland 21740  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Rest Haven Cemetery   |  | 20c. LOCATION — City or Town, State<br>Hagerstown, Maryland  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Scott Minnich</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>MINNICH FUNERAL HOME<br>415 E. Wilson Blvd., Hagerstown, Md. 21740  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Congestive Failure</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |  | Approximate Interval Between Onset and Death<br>4 yrs   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>pneumonia</u>  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 28c. INJURY AT WORK<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Max E. Byrkit</i>   |  |   |  | 29c. LICENSE NUMBER<br>D00936   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-20-90   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Max E. Byrkit, M.D., 28 W. Potomac St., Williamsport, Maryland 21795   |  |   |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 20 '90   |  | REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26623

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WILLIS SWANSON CROCKETT</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>8</b> DAY <b>30</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>4:32 A</b> <b>M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>223-24-6675</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>08-16-09</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ALICE BYRD TAWES NURSING HOME</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Crisfield</b>   |  | 9c. COUNTY OF DEATH<br><b>Somerset</b>  |  |
| 10a. STATE<br><b>VA</b>   |  | 10b. COUNTY<br><b>Accomack</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Tangier</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO           |  |
| 10e. STREET AND NUMBER<br><b>Box 31 - West Ridge</b>  |  |  |  | 10f. ZIP CODE<br><b>23440</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Grade 5</b><br>College (1-4 or 5+) <b>--</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Waterman</b>                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Seafood</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Jesse Crockett</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Amanda Charnock</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Stella M. Crockett (wife)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as # 10 a b c d e f g</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION <b>09-01-90</b><br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Sunnyridge Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Crisfield, MD</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert B. Brubaker</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bradshaw &amp; Sons Funeral Home</b><br><b>306 W. Main St. - Crisfield, MD 21817</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebral Vascular Accident</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. <b>Arteriosclerotic Cerebral Vas. Disease</b><br>c. <b>Alzheimer's Disease</b><br>d. <b>Coronary Artery Disease</b> |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>Years</b><br><b>Years</b>                              |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's Disease</b><br><b>Coronary Artery Disease</b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                        |  | 26. PLACE OF DEATH (Check only one)<br>OTHER: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                      |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>James A. Sterling, M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D10214</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/30/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>James A. Sterling, M.D. - 320 W. Main St. - Crisfield, MD 21817</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP - 6 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Virginia

05-10-50

14

Revised

Revised

Revised

Revised

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

90 26624

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |   |
|---|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SHARE WING CHIN</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 12 90</b>   |  | 3. TIME OF DEATH<br><b>1:28 M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>578 46 9139</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>67 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>01 21 23</b>                               |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>CHINA</b>  |  |   |  | 9a. FACILITY NAME (If not Institution, give street and number)<br><b>SOUTHERN MARYLAND HOSPITAL</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>C LINTON</b>                               |   |
| 9c. COUNTY OF DEATH<br><b>PRINCE GEORGES</b>  |  |   |  |   |  |  |   |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |  |   |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>CHARLES</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>WALDORF</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>41 OAK MANOR DRIVE</b>   |  |   |  | 10f. ZIP CODE<br><b>20601</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>ASIAN</b>           |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b><br>College (1-4 or 5+) <b>RESTAURANT OWNER</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>RESTAURANT OWNER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HONG KWAN CHIN</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SAM KIM NG</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>TUI NGOOK CHIN (WIFE)</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>41 OAK MANOR DRIVE WALDORF, MARYLAND 20601</b>  |  |   |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GEORGE WASHINGTON HOSPITAL</b>   |  | 20c. LOCATION — City or Town, State<br><b>ADELPHI, MARYLAND</b>   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert M. Mady</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Congestive Heart Failure</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>CHRONIC ARTERY DISEASE</b><br/> <b>INSULIN DEPENDENT DIABETES</b> </div> <div style="width: 35%;">           Approximate Interval Between Onset and Death         </div> </div> |  |   |  |   |  |  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Renal Failure</b>  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |
|   |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO     |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Terence Bertele</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D30041</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/12/90</b>                                |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Terence Bertele, M.D., 7501 Surratts Road, Clinton, MD 20735</b>  |  |   |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 17 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26625

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CATHERINE P. CROUCH</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPTEMBER 10, 1990</b>  |  | 3. TIME OF DEATH<br><b>5:30 PM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-46-4736</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (in yrs. last birthday)<br><b>94</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>JULY 25, 1896</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>ILLINOIS</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>1959 SEMINARY PLACE</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SILVER SPRING</b>  |  |
| 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>SILVER SPRING</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>1959 SEMINARY PLACE</b>   |  |
| 10f. ZIP CODE<br><b>20910</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1</b> College (1-4 or 5+) <b>1</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>SECRETARY</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. DEPT./GOVERNMENT</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>GABRIEL A. PARISH</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY M. UNKNOWN</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>LALLY THOMAS (FRIEND)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13401 NORDEN DRIVE, SILVER SPRING, MARYLAND 20906</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>METROPOLITAN CREMATORY</b>  |  | 20c. LOCATION — City or Town, State<br><b>ALEXANDRIA, VIRGINIA</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W., SIL. SP., MD 20901</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Stroke</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF): <b>Cerebral Vascular disease</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D19170</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/11/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>10313 GEORGIA AVE. SILVER SPRING, MD 20902</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 13 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





90 26626

1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>May E. Crum</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 - 2 1990</b>  |  | 3. TIME OF DEATH<br><b>8:20 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-01-4439</b>  |  | 5. SEX<br><b>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</b>  |  | 6. AGE (In yrs. last birthday)<br><b>93 YRS.</b>   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Oct 22, 1896</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>NATIONAL LUTHERAN HOME</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ROCKVILLE</b>  |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY CO.</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |  |  |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>MONTGOMERY CO.</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>CHEVY CHASE</b>  |  | 10d. INSIDE CITY LIMITS?<br><b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>   |  |
| 10e. STREET AND NUMBER<br><b>4708- BRADLEY BLVD.,</b>  |  |  |  | 10f. ZIP CODE<br><b>20815</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><b>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br/>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b><br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12</b>  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>SALES CLERK</b>  |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>UNKNOWN</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ARTHUR FARRELL</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>BLANCHE BROWN</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>REV. DR. REICHARD</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9701- VEIRS DR., ROCKVILLE, MD. 20850</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br/>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CEDAR HILL CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>SUITLAND, MARYLAND</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>William W. Dyson</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>THE HYSOYNG CO., INC.<br/>1300-N STREET, N.W. WASH., DC</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Clinical CHOLANGIOCARCINOMA</i></b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>10 months</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I.  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b>   |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b> |  |
| 26. PLACE OF DEATH (Check only one)<br><b>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br/>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>   |  | 27. MANNER OF DEATH<br><b>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br/>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined</b> |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><b>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br/>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Thomas E. Doolley MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>016458</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Sept 3, 1990</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Thomas E. Doolley MD 17964 Redesia Avenue Chevy Chase MD 20832</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 14 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26627

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>William Edward DEY JR.</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> - DAY <b>8</b> - YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>1135</b> M   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>218-32-7938</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>54</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>2/11/36</b>                                    |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Baltimore, MD</b>   |  |   |  |   |  |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b>   |  |   |  | 9b. CITY/TOWN OR LOCATION OF DEATH<br><b>Annapolis</b>  |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>  |   |
| 10a. STATE<br><b>Maryland</b>  |  |   |  | 10b. COUNTY<br><b>Anne Arundel</b>  |  | 10c. CITY/TOWN OR LOCATION<br><b>Edgewater</b>  |   |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   |   |
| 10e. STREET AND NUMBER<br><b>1740 Shady Side Dr.</b>   |  |   |  | 10f. ZIP CODE<br><b>21031</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>4</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Attorney</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>I.R.S.</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William E. Dey Sr.</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Margaret Hinderer</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Rosa C. Dey</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1740 Shady Side Drive, Edgewater, MD</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hardesty Funeral Home P.A.<br/>12 Ridgely Ave. Annapolis, MD 21401</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. Cardiopulmonary Arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Coronary Artery Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Hypertension, Diabetes mellitus, Tobacco Smoking</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Renal Failure</b>   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> N/A<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> MO   |  |   |  | 29c. LICENSE NUMBER<br><b>032654</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/8/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John P. Serlemittos MO</b><br><b>Columbia Freestate 14MO</b><br><b>2525 Rive Rd, Annapolis, MD</b>   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 10 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Samuel BARNETT DeGrate  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-9-90  |  | 3. TIME OF DEATH<br>2:17AM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>215-38-9832  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>64 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>DEC. 3-1925  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>TEXAS   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Anne Arundel General Hospital   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Annapolis   |  |
| 9c. COUNTY OF DEATH<br>Anne Arundel Co.   |  |  |  | 10a. STATE<br>MD  |  | 10b. COUNTY<br>ANNE ARUNDEL  |  |
| 10c. CITY, TOWN OR LOCATION<br>ANNAPOLIS  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>1911 C- COPELAND   |  |
| 10f. ZIP CODE<br>21403  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>W.W. 11   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>BLK  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) ?  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>RETIRED LABORER  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>*****  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>ALBERT DEGRATE   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MAMIE CARTER   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>BEDELIA GREEN   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1911 C-COPELAND ST. ANNAPOLIS, MD. 21403   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>PINELAWN MEM. PARK  |  | 20c. LOCATION — City or Town, State<br>ANNAPOLIS, MD.  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>CHARLES E. HICKS 11/2/90   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>HICKS FUNERAL HOME 1922 FOREST DR. ANNA. MD 21401   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple injuries<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I.   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> INPATIENT 2 <input checked="" type="checkbox"/> ER/OUTPATIENT 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |  |  |
| 28a. DATE OF INJURY<br>(Month, Day, Year)<br>9-9-90   |  | 28b. TIME OF INJURY<br>12:47AM   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>Pedestrian struck by auto   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>Street  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>West St/Chingiapine, Annapolis  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>[Signature]  |  | 29c. LICENSE NUMBER<br>OCME  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br>9-10-90  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>FRANK PERETTI, MD<br>111 Penn Street, Baltimore, MD 21201  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 13 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

9 27-11

12

13 14 15 16

17

18

19

20

21 22

23

24

25

26

27

28

29 30 31 32

33

34 35 36 37

38

39

40

41 42

43 44

45

46

47 48 49 50

90 26629

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>JOHN DERMOT   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>September 13, 1990  |  |  |  | 3. TIME OF DEATH<br>0110 M  |  |
| 4. SOCIAL SECURITY NUMBER<br>213-70-8687  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>59 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>3-29-1931                                  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Ireland   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Peninsula General Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Salisbury  |  |  |  | 9c. COUNTY OF DEATH<br>Wicomico   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |  |   |  |
| 10a. STATE<br>MD  |  | 10b. COUNTY<br>Worcester   |  | 10c. CITY, TOWN OR LOCATION<br>Ocean City   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br>801 N. Philadelphia Ave.  |  |  |  | 10f. ZIP CODE<br>21842  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>Ireland   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Carpenter   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Hotel Complex                                      |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Dermot Doyle   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anne Nimo  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Peter J. Doyle  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Rt. 2 Box 150 Parsonsburg, MD 21849  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Parsons Cemetery   |  |   |  | 20c. LOCATION — City or Town, State<br>Salisbury, MD                                 |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>B. Keith Shippin   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Bounds Funeral Home Salisbury, MD   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung Cancer<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br>1 yr.   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|   |  |  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>William J. Nagel, MD   |  |  |  |   |  | 29c. LICENSE NUMBER<br>022160  |  | 29d. DATE SIGNED (Month, Day, Year)<br>Sept 13, 1990  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>William J. Nagel, MD PGHMC Salisbury MD 21801  |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 14 '90   |  | 32. REGISTRAR'S SIGNATURE<br>John Doyle  |  |   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26630

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>RALPH BURRIS DAVIS  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>September 5, 1990   |  | 3. TIME OF DEATH<br>0225 M  |   |
| 4. SOCIAL SECURITY NUMBER<br>212-18-6086  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>76 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>NOV. 26, 1913  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Peninsula General Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Salisbury  |  | 9c. COUNTY OF DEATH<br>Wicomico   |   |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |   |
| 10a. STATE<br>MARYLAND  |  | 10b. COUNTY<br>WICOMICO  |  | 10c. CITY, TOWN OR LOCATION<br>DELMAR   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>LINE ROAD   |  |  |  | 10f. ZIP CODE<br>21875  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WWII   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                                 |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12)<br>6  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>GROWER  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>POULTRY   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>BROGAN DAVIS   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>EDITH (MAIDEN SURNAME UNKNOWN)   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>HERMAN D. HOFFMAN   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>509 HAYWARD AVENUE, FRUITLAND, MARYLAND 21826  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MELSON CHURCH CEMETERY   |  | 20c. LOCATION — City or Town, State<br>DELMAR, MARYLAND   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Edward D. Zeller</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>ZELLER FUNERAL HOME<br>SALISBURY, MD 21801  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARCINOMA OF LUNG.</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>COPD</u>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |   |  |   |   |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Roger Merrill</i>   |  |  |  | 29c. LICENSE NUMBER<br>D21953   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9 5 90   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Roger Merrill 102 Power St, Salisbury  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 12 90  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26631

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>William B. DAVIS</b>  |  |  |  | 2. DATE OF DEATH 09/12/90<br>MONTH DAY YEAR<br><b>9/12/90</b>   |  | 3. TIME OF DEATH 9:30 P M<br><b>9:30 P</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>215-28-6470</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>59</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>07/12/1931</b>  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Dorchester General Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cambridge Md.</b>   |  | 9c. COUNTY OF DEATH<br><b>Dorchester</b>  |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>Dorchester</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Cambridge</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>5111 David Greene Rd.</b>   |  |  |  | 10f. ZIP CODE<br><b>21613</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>U.S.A.R.</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                           |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>8</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Electrical Engineer</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>manufacturing</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Paul E. Davis</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Eleanor Danaker</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charlotte M. Davis</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5111 David Greene Rd. Cambridge Md. 21613</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>E. New Market Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>E. New Market Md.</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Kenneth R. Thomas Jr.</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Thomas Funeral Home<br/>700 Locust St. Cambridge Md. 21613</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC CARCINOMA OF PANCREAS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
|  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO              |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Michael A. Moskewicz MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>2-16609</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/12/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MICHAEL A. MOSKEWICZ MD 503 BYEN ST. CAMBRIDGE MD 21613</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 17 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Gelia Davidson-Randall</b>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

of which I have 5

90 26632

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Charles F. Doolan</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>9</i> DAY <i>19</i> YEAR <i>90</i>   |  | 3. TIME OF DEATH<br><i>8:17 A</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>023-12-8064</i>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>66</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>4/10/1924</i>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Massachusetts</i>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>CARROLL COUNTY GENERAL HOSPITAL</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>WESTMINSTER</i>  |  |
| 9c. COUNTY OF DEATH<br><i>CARROLL</i>   |  |  |  | 10a. STATE<br><i>MARYLAND</i>   |  | 10b. COUNTY<br><i>CARROLL</i>  |  |
| 10c. CITY, TOWN OR LOCATION<br><i>WESTMINSTER</i>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><i>400 FALCON COURT, APT. 1C</i>   |  |
| 10f. ZIP CODE<br><i>21157</i>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA.</i>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>WHITE</i>   |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>4</i>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>SALESMAN</i>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>HARDWARE</i>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>CHARLES F. DOOLAN</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>EUDORA MAY FAY</i>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>MRS. ROSALIND I. DOOLAN</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>400 FALCON COURT, APT. 1C, WESTMINSTER, MD. 21157</i>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>EVERGREEN MEMORIAL GARDENS</i>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><i>FINKSBURG, MD. 21157</i>  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>A. Lang Nightingale</i>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><i>ECKHARDT FUNERAL CHAPEL<br/>OWINGS MILLS, MD. 21117</i>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>CARDIO-RESPIRATORY ARREST</i><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF): <i>Acute M.I.</i><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>COPD</i><br><i>CA STOMACH</i>  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  |  |  | 28b. TIME OF INJURY<br><i>M</i>   |  |  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Manuel J. Sevilla</i>   |  |  |  |
| 29c. LICENSE NUMBER<br><i>018099</i>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9-19-90</i>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>611 N. W. Rd. WESTMINSTER, MD.</i>  |  |  |  | 31. DATE FILED (Month, Day, Year)<br><i>SEP 20 '90</i>  |  |  |  |
| 32. REGISTRAR'S SIGNATURE<br><i>J. Davidson-Randall</i>   |  |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

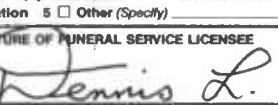

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH REG. NO.

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |   |  |
|---|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Thisbe Elizabeth DEITZ</b>   |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 21, 1990</b>   |  | 3. TIME OF DEATH<br><b>10:00 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>489-42-4780</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS.  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>May 22, 1901</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Ohio</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Frederick Memorial Hospital</b>  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Frederick</b>   |  | 9c. COUNTY OF DEATH<br><b>Frederick</b>   |  |
| RESIDENCE OF DECEDENT   |  |  |   |   |  |   |  |
| 10a. STATE<br><b>Md.</b>  |  | 10b. COUNTY<br><b>Frederick</b>  |   | 10c. CITY, TOWN OR LOCATION<br><b>Frederick</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>31 W. Patrick St.</b>  |  |  |   | 10f. ZIP CODE<br><b>21701</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>            |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Reuben F. Shultz</b>  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ermine Cooke</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Barbara D. Mehl</b>  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>815 Montclair Ave. Frederick, Md. 21701</b> |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>  |   | 20c. LOCATION — City or Town, State<br><b>Smithsburg, Md.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Davis Funeral Home<br/>Rt 3 Box 78 Smithsburg, Md. 21783</b>  |   |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Aspiration Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b.<br>c.<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><br>25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><br>26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DQA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)<br><br>27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide<br><br>28a. DATE OF INJURY (Month, Day, Year)<br><br>28b. TIME OF INJURY<br><b>M</b><br><br>28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><br>28d. DESCRIBE HOW INJURY OCCURRED<br><br>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><br>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><br>29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><br>29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>W. M. Middelick, M.D.</b><br><br>29c. LICENSE NUMBER<br><b>D12482</b><br><br>29d. DATE SIGNED (Month, Day, Year)<br><b>9/22/90</b><br><br>30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Julio Menocal Parkview Medical Center Frederick, Md. 21701</b><br><br>31. DATE FILED (Month, Day, Year)<br><b>SEP 24 '90</b><br><br>32. REGISTRAR'S SIGNATURE<br> |  |  |   |   |  |   |  |

2011.01.01

2011.01.01



DOB: 04/14/21

90 26634

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |   |   |  |  |  |
|---|--|---|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ALFRED T. DASHIELL  |  |   |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9 1 90  |  | 3. TIME OF DEATH<br>2355 M   |  |
| 4. SOCIAL SECURITY NUMBER<br>217-16-7594  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br>69 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>04-14-1921  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Peninsula General Hospital  |  |   |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Salisbury  |  | 9c. COUNTY OF DEATH<br>Wicomico  |  |
| 10a. STATE<br>Maryland  |  |   |   | 10b. COUNTY<br>Somerset   |  | 10c. CITY, TOWN OR LOCATION<br>Princess Anne, MD                                     |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |   |   |  |  |  |
| 10e. STREET AND NUMBER<br>413 Pine Knoll Drive  |  |   |   | 10f. ZIP CODE<br>21853  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>W. W. II |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>H.S. Graduate  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Animal Control                                 |   | 15b. KIND OF BUSINESS/INDUSTRY<br>Somerset County, MD   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Arza T. Dashiell   |  |   |   | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Medora Turpin  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Alfred Thomas Dashiell  |  |   |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3209 Waterway Circle - Memphis, Tenn. 38119  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>St. Andrews Episcopal Cemetery  |   | 20c. LOCATION — City or Town, State<br>Princess Anne, MD  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Robert H. Bradshaw, Jr.  |  |   |   | 22. NAME AND ADDRESS OF FACILITY<br>Bradshaw & Sons Funeral Home<br>306 W. Main St. - Crisfield, MD 21817   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Septic Shock<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>Pneumonia<br>possible intraabdominal infection<br>MI |  |   |   |   |  |  | Approximate Interval Between Onset and Death<br>8h<br>?<br>?<br>~8h  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>partial small bowel obstruction.  |  |   |   |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |   |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |   | 28e. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Steve L. Bradshaw MD   |  |   |   | 29c. LICENSE NUMBER<br>D30693   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/2/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>560 Riverside Dr Salisbury MD 21801  |  |   |   |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP - 6 '90  |  |   |   | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26635

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Myrtle M. DeHaven</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 11, 1990</b>   |  | 3. TIME OF DEATH<br><b>12:15 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-38-1521</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>94</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Sept. 2, 1896</b>                       |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Wilson Health Care Center</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Gaithersburg</b>                           |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>   |  |  |  |
| 10b. COUNTY<br><b>Montgomery</b>   |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>Gaithersburg</b>  |  |  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>301 Russell Avenue</b>   |  |  |  |
| 10f. ZIP CODE<br><b>20877</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>           |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>6</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William H. Kenney</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Alice Miller</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Richard L. DeHaven</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8604 Hartsdale Avenue, Bethesda, Maryland 20817</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Union Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Burtonsville, Maryland</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert A. Pumphrey</i> MO0198  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Robert A. Pumphrey Funeral Home/<br/>Bethesda-Chevy Chase, Inc.<br/>7557 Wisconsin Ave. Bethesda, MD 20814-3501</b>   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Bronchopneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>1 week</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cerebrovascular Arteriosclerosis</b><br><b>Chronic organic brain syndrome</b>   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: In the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Henry C. Scruggs, M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D12504</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Sept. 12, 1990</b>                         |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Henry C. Scruggs, M.D. 5413 West Cedar Lane, Bethesda, Maryland 20814</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 13 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26636

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Edward Francis Daly</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPTEMBER 13, 1990</b>   |  | 3. TIME OF DEATH<br><b>10:45 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-26-7227</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>11-25-12</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>WASHINGTON, D.C.</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>HOLY CROSS HOSPITAL</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SILVER SPRING</b>  |  |
| 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |  |  | 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>SILVER SPRING</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>105 WOODMOOR DRIVE</b>  |  |
| 10f. ZIP CODE<br><b>20901</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/><br><b>4</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>ACCOUNTANT</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>FEDERAL GOVERNMENT</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>TIMOTHY J. DALY</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SUSANNAH HAYES</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>LaVon W. Daly (WIFE)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>105 WOODMOOR DRIVE SILVER SPRING, MARYLAND 20901</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GATE OF HEAVEN CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>SILVER SPRING, MARYLAND</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Francis J. Collins</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W. SIL SPR., MD. 20901</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |  |  |   |  |  |  |
| a. <b>Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| b. <b>Emphysema</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| c. <b>Brachyogenic Carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| d. <b>Pulmonary Embolus</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER<br>(Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Jay Weiner MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>024571</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/13/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Jay Weiner MD 4701 Rockville Rd Rockville MD</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 17 '90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26637

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |  |   |   |  |
|---|--|--|---|---|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Dorothy Jean Elms   |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09/05/90  |  | 3. TIME OF DEATH<br>5:50pm M  |   |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>65 YRS. |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>07/09/25 |   | 8. BIRTHPLACE (State or Foreign Country)<br>West Virginia |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Chesapeake Manor  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Arnold   |  | 9c. COUNTY OF DEATH<br>Anne Arundel   |   |  |
| 10a. STATE<br>MD  |  | 10b. COUNTY<br>Anne Arundel  |   | 10c. CITY, TOWN OR LOCATION<br>Annapolis  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |   |  |
| 10e. STREET AND NUMBER<br>700 Mountalban Drive  |  |  |   | 10f. ZIP CODE<br>21401  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White   |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker   |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Home  |  |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Harry Calhoun  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Hallie McLain  |  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. Richard W. Elms   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>700 Mountalban Drive Annapolis MD 21401  |  |   |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Highlawn Mem. Park   |   | 20c. LOCATION — City or Town, State<br>Oak Hill W. Virginia   |  |   |   |  |
| 21. SIGNATURE OF FURNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>495 Ritchie Hwy.<br>Barranco Funeral Home Severna Park MD 21146   |  |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic Carcinoma of the Breast</i><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |   |   |  |   | Approximate Interval Between Onset and Death              |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |   |  |
|   |  |  |   |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |   |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |   |  |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature] Medical Director</i>   |   | 29c. LICENSE NUMBER<br>D21684   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-7-90   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>C-V-CYRIAC-M.D. 1600 CRAIG HWY, GLENBURNIE MD 21061  |  |  |   |   |  |   |   |  |
| 31. FILED (Month, Day, Year)<br>SEPT 11 1990  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |   |   |  |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2000-0000 25 1000 1 1987



90 26638

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Wesley Edward Evans</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>5</b> YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>1:30 pm</b>                                      |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-10-0291A</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>December 18, 1917</b>         |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Box 360 B</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Crisfield, Md.</b>            |  |
| 9c. COUNTY OF DEATH<br><b>Somerset</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>  |  |   |  |
| 10b. COUNTY<br><b>Somerset</b>   |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>Crisfield</b>  |  |   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>Box 360 B</b>   |  |   |  |
| 10f. ZIP CODE<br><b>21817</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>7th Grade</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Cutlery</b>                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Cutlery (Carvel Hall)</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Cleveland E. Evans</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Martha Riggan Evans</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Honwood Evans</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Box 360 B, Crisfield, Md. 21817</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Crisfield Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Crisfield, Md.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Sterling Funeral Home Crisfield, Md.</b>  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>myocardial infarction</b><br><b>Peptic ulcer disease</b><br>Approximate Interval Between Onset and Death<br><b>Acute</b><br><b>months</b> |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>9/6/90</b>  |  |   |  |
| 28b. TIME OF INJURY<br><b>M</b>  |  |  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>M. D. Barkhan M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>12764</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/6/90</b>                    |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>M. D. BARKHAN M.D. Rt-413 CRISFIELD, MD</b>  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP - 7 '90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

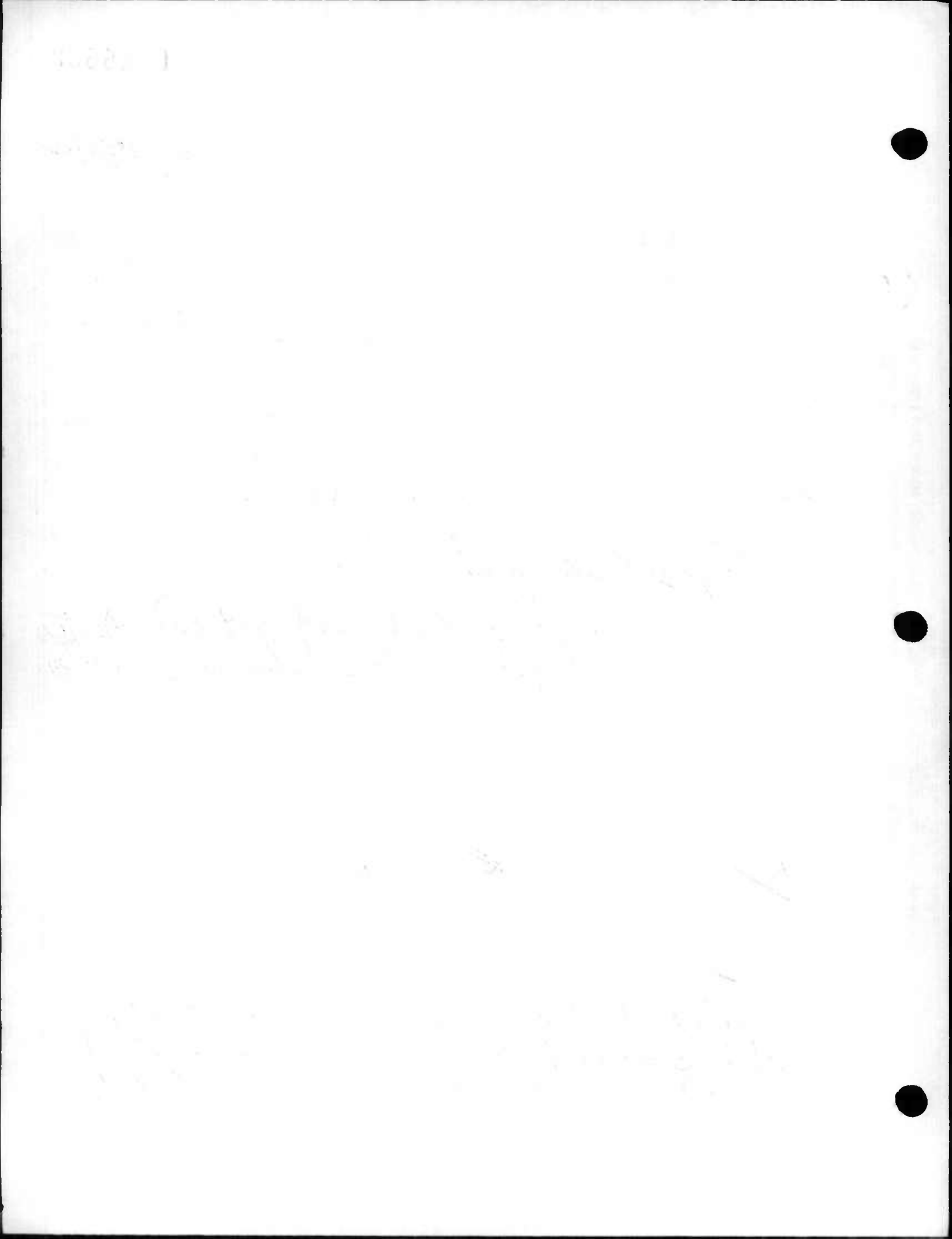
BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100000



90 26639

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROLAND J. EVANS</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>13</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>10:15 AM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>278-10-1140</b>   |  | 5. SEX<br><b>XX</b> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>3-24-1898</b>                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Hillhaven Nursing Center</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Adelphi,</b>  |  | 9c. COUNTY OF DEATH<br><b>Prince George</b>   |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Prince George</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Adelphi</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>3210 Powder Mill Road</b>  |  |   |  | 10f. ZIP CODE<br><b>20783</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12 years</b>   |  | 18a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Steele Worker</b>   |  | 18b. KIND OF BUSINESS/INDUSTRY<br><b>private</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>David Evans</b>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elizabeth Jayne</b>   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Phyllis Evans</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4603 Marie Street Beltsville, Md. 20705</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Girard City Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Girard, Ohio</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Ronald V. Borgwardt</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Borgwardt Funeral Home</b><br><b>4400 Powder Mill Rd. Beltsville, Md. 20705</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ATHEROSCLEROSIS</b>  |  |   |  |   |  |   |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| b. <b>COPD</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |   |  |
| c. <b>LEFT BKA 8/90</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| d.  |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEMENTIA</b>   |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Ch Benner MD</b>  |  | 29c. LICENSE NUMBER<br><b>D31563</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-13-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CHARLES BENNER MD 11161 NEW HAMPSHIRE, SILVER SPRG, 20904</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 18 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Gordon Rodell</b>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26640

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Alma Loane Flynn</u>   |  |  |  | 2. DATE OF DEATH<br>MONTH <u>09</u> DAY <u>2</u> YEAR <u>90</u>   |  | 3. TIME OF DEATH<br><u>7:30</u> P M  |  |
| 4. SOCIAL SECURITY NUMBER<br><u>216-18-5237</u>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><u>66</u> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>03-29-24</u>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>Maryland</u>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><u>Anne Arundel Medical Center</u>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Annapolis</u>  |  |
| 9c. COUNTY OF DEATH<br><u>Anne Arundel</u>  |  |  |  | 10a. STATE<br><u>Maryland</u>   |  | 10b. COUNTY<br><u>Anne Arundel</u>   |  |
| 10c. CITY, TOWN OR LOCATION<br><u>Riva</u>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><u>504 Sweet Gum Road</u>  |  |
| 10f. ZIP CODE<br><u>21140</u>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>White</u>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>11</u> College (1-4 or 5+) <u>11</u>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Homemaker</u>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Home</u>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>George Washington Galloway</u>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Martha Cadle</u>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Robert Y. Flynn</u>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>504 Sweet Gum Road, Riva, Maryland 21140</u>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Metropolitan Crematory</u>   |  | 20c. LOCATION — City or Town, State<br><u>Alexandria, VA</u>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Donald A. Lytle</u>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>Taylor Funeral Chapel 21401</u><br><u>147 Gloucester St., Annapolis, MD</u>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Brain stem Hemorrhage</u>  |  |  |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  |  |  |   |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Poly myalgia Rheumatica</u><br><u>Labile Hypertension</u>  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  |   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  |  |  |   |  |  |  |
| 28b. TIME OF INJURY<br>M <u>1</u> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Anthony Caputo</u>  |  |  |  |   |  |  |  |
| 29c. LICENSE NUMBER<br><u>213577</u>  |  |  |  |   |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><u>9-9-90</u>  |  |  |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Anthony Caputo 132 Holiday Court, Annapolis, MD 21401</u>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><u>SEPT 11 1990</u>  |  |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. The certificate should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26641

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HELEN S. FORD</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 11 90</b>  |  | 3. TIME OF DEATH<br><b>0045A</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-54-7797</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10-4-1904</b>                          |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Md.</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Peninsula General Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Salisbury</b>                          |  |
| 9c. COUNTY OF DEATH<br><b>Wicomico</b>   |  |  |  |   |  |  |  |
| 10a. STATE<br><b>Md.</b>   |  |  |  | 10b. COUNTY<br><b>Wicomico</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Salisbury</b>                                  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>Rt. 5 Old Quantico Road</b>   |  |  |  | 10f. ZIP CODE<br><b>21801</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>          |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>7</b> College (1-4 or 5+) <b>7</b>   |  | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Home Maker</b>              |  | 18b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Sidney Smith</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lucy Virginia Porter</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Roland W. Ford</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17705 Lisa Drive, Derwood, Maryland 20855</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parsons Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Salisbury, Md.</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>MOO417</b><br><i>Edmund D. Wessell II</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Messick Funeral Home, P.O. Box 61<br/>Bivalve, Maryland 21814</b>                                     |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>COLOON CARCINOMA - METASTATIC</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PNEUMONIA</b><br><b>CARDIOMYOPATHY - CONGESTIVE</b> |  |  |  |   |  |  | Approximate Interval Between Onset and Death |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | HOSPITAL:<br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA               |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                              |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Donald P. Lutz MD</i>  |  | 29c. LICENSE NUMBER<br><b>D36576</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/11/90</b>                            |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>560 RIVERSIDE DRIVE SALISBURY MD 21801</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 14 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Fawcett</i>  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26642

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LLOYD KENNETH FEARNOW</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>21</b> YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>1:15 A.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-16-0233</b>   |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 15, 1902</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Clearview Nursing Home</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Washington</b>  |  |   |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Washington</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>11 Mealey Parkway</b>   |  |
| 10f. ZIP CODE<br><b>21740</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br><b>2</b> <input checked="" type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |  |   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>10</b> Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Partner - Owner</b>  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Farm Machinery Sales</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Otterbein Fearnow</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ida May Miller</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Wayne E. Kiser</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>840 Kenley Avenue, Hagerstown, Md. 21740</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>8</b> <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rest Haven Cemetery</b>  |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>Hagerstown, Wash., Md.</b>  |  |   |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>R. Neil Brady</b>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Andrew K. Coffman Funeral Home, Inc.<br/>40 E. Antietam St., Hagerstown, Md. 21740</b>   |  |   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>acute congestive heart failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>arteriosclerotic heart disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>hypertension</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>diabetes mellitus</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</b><br><b>Dehydration, renal failure</b><br><b>alcohol intoxication with pancreatitis</b> |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>8</b> <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>9/20/90</b>  |  |  |  |
| 28b. TIME OF INJURY<br><b>M</b>   |  |   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  | 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Edson B. Moody</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>00 7857</b>   |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>9/20/90</b>   |  |   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Edson B. Moody 1190 N.E. Aetna Rd. Hagerstown, Md 21740</b>   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 24 '90</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1950

Handwritten signature or text at the bottom center.

1950

90 26643

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FORD, R. Cyrus</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> - DAY <b>20</b> - YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>10:45 P.M.</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>229-20-2849A</b>  |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <b>2</b> <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>99</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 14, 1891</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>   |  |  |  |   |  |  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Ravenwood Lutheran Home</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>  |  | 9c. COUNTY OF DEATH<br><b>Washington</b>   |   |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Washington</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>   |   |
| 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  |  |  |   |  |  |   |
| 10e. STREET AND NUMBER<br><b>42 East Avenue</b>   |  |  |  | 10f. ZIP CODE<br><b>21740</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 11. MARITAL STATUS<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                         |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>unknown</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>self-employed</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>plumber</b>  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Harvey E. Ford</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jennie A. Gearhart</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Robert H. Ford, Sr.</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Route 10, Box 21A, Hagerstown, Md. 21740</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rest Haven Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Hagerstown, Maryland</b>  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Scott Minnick</b>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MINNICH FUNERAL HOME</b><br><b>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>   |  |   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrest</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Cardio-myopathy</b><br><b>Arteriosclerotic Heart Disease</b><br><b>Arteriosclerosis, gen</b> |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Myocardial Infarction (mid Aug '90)</b>  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John N. Feuder, M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D04262</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>21 Sept. 1990</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John N. Feuder, M.D. 130 E. Antietam St Hagerstown MD 21740</b>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 21 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten signature

1954

90 26644

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Amelia Susan FINCH</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 20, 1990</b>   |  | 3. TIME OF DEATH<br><b>4:15 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>714 03 4083 D</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>6/29/06</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Hanover, Pa.</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Homewood Retirement Center</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Williamsport</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Washington</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Washington</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Williamsport</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>2750 Virginia Ave.</b>  |  |
| 10f. ZIP CODE<br><b>21795</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>homemaker</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>home</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Bange</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Cora Kopp</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Robert E. Kuczynski</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Rt. 3 Box X315 Garis Shop Rd. Hagerstown, Md.</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Loudon Park Cemetery</b>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Gerald N. Minnich</i>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Gerald N. Minnich 305 N. Potomac St.<br/>Funeral Home Hagerstown, Md.</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Adenocarcinoma of the Colon with liver metastases</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate Interval Between Onset and Death<br><b>6 months</b> |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  |  |  | 28b. TIME OF INJURY<br>M  |  |  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robert Brull, M.D. personal physician</i>   |  |  |  |
| 29c. LICENSE NUMBER<br><b>D04359</b>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/21/90</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print)<br><b>Robert Brull, M.D. 1459 Potomac Ave Hagerstown MD 21740</b>   |  |  |  | 31. DATE FILED (Month, Day, Year)<br><b>SEP 24 90</b>   |  |  |  |
| 32. REGISTRAR'S SIGNATURE<br><i>Jane Davidson-Randall</i>   |  |  |  | 33. REGISTRAR'S SIGNATURE<br><i>m D 21740</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26645

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |                                 |  |  |  |   |  |
|--|--|---------------------------------|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Jose Luis Faria</u>   |  |                                 |  | 2. DATE OF DEATH<br>MONTH <u>09</u> DAY <u>15</u> YEAR <u>90</u>   |  | 3. TIME OF DEATH<br><u>3 30 P M</u>   |  |
| 4. SOCIAL SECURITY NUMBER<br><u>212-64-9374</u>  |  | 5. SEX<br><u>1</u> M <u>2</u> F |  | 6. AGE (In yrs. last birthday)<br><u>44</u> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>Jan. 27, 1946</u>                                      |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>PORTUGAL</u>  |  |                                 |  | 9a. FACILITY NAME (If not Institution, give street and number)<br><u>10009 Clue Dr.; Bethesda MD</u>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Bethesda, MD</u>  |  |
| 9c. COUNTY OF DEATH<br><u>MONTGOMERY, MD</u>   |  |                                 |  | 10a. STATE<br><u>MD</u>  |  | 10b. COUNTY<br><u>Montgomery</u>  |  |
| 10c. CITY, TOWN OR LOCATION<br><u>Bethesda, MD</u>   |  |                                 |  | 10d. INSIDE CITY LIMITS?<br><u>10</u> YES <u>2</u> NO  |  | 10e. STREET AND NUMBER<br><u>10009 Clue Dr., Bethesda MD</u>  |  |
| 10f. ZIP CODE<br><u>20817</u>  |  |                                 |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>US</u>   |  | 11. MARITAL STATUS<br><u>1</u> Never Married <u>2</u> Married<br><u>3</u> Widowed <u>4</u> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <u>1</u> YES <u>2</u> NO<br>IF YES, GIVE WAR OR DATES  |  |                                 |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><u>1</u> YES <u>2</u> NO Specify:   |  |   |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>white.</u>   |  |                                 |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>8</u> College (1-4 or 5+) <u>-</u>  |  |   |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Maintenance</u>                                |  |                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Zalco Realty Incorporated</u>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Goao Faria</u>   |  |                                 |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Conceicao Gonsalves</u>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Maria C. Faria</u>  |  |                                 |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>10009 Clue Drive Bethesda, Maryland 20817</u>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><u>1</u> Burial <u>2</u> Cremation <u>3</u> Removal from State<br><u>4</u> Donation <u>5</u> Other (Specify)                         |  |                                 |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Parklawn Memorial Park</u>  |  |   |  |
| 20c. LOCATION — City or Town, State<br><u>Rockville, Maryland</u>  |  |                                 |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Will E. Bann</u> M00672  |  |   |  |
| 22. NAME AND ADDRESS OF FACILITY<br><u>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814</u>               |  |                                 |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>metastatic gastric cancer</u><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><u>liver failure</u><br><u>cardiopulmonary failure</u><br><u>cancer cachexia</u> |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><u>1</u> YES <u>2</u> NO   |  |                                 |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><u>1</u> YES <u>2</u> NO  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><u>1</u> YES <u>2</u> NO   |  |                                 |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <u>1</u> Inpatient <u>2</u> ER/Outpatient <u>3</u> DOA OTHER: <u>4</u> Nursing Home <u>5</u> Residence <u>6</u> Other (Specify)   |  |   |  |
| 27. MANNER OF DEATH<br><u>1</u> Natural <u>5</u> Pending investigation<br><u>2</u> Accident <u>6</u> Could not be determined<br><u>3</u> Suicide <u>8</u> Homicide |  |                                 |  | 28a. DATE OF INJURY (Month, Day, Year)<br><u>09/15/90</u>  |  |   |  |
| 28b. TIME OF INJURY<br><u>M</u>  |  |                                 |  | 28c. INJURY AT WORK?<br><u>1</u> YES <u>2</u> NO   |  |   |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |                                 |  | 28e. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |                                 |  | 29a. CERTIFIER (Check only one)<br><u>1</u> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><u>2</u> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Albert K. Lee MD</u>   |  |                                 |  | 29c. LICENSE NUMBER<br><u>D 31282</u>  |  |   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><u>09.15.90</u>   |  |                                 |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Albert K. Lee M.D.</u><br><u>8218 Wisconsin Avenue #105, Bethesda MD 20814</u>   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><u>SEP 17 '90</u>   |  |                                 |  | 32. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial and permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the paper is devoted to a general discussion of the problem. It is shown that the problem is of great importance in the theory of the structure of the atom. The second part of the paper is devoted to a detailed discussion of the problem. It is shown that the problem is of great importance in the theory of the structure of the atom.

The third part of the paper is devoted to a detailed discussion of the problem. It is shown that the problem is of great importance in the theory of the structure of the atom. The fourth part of the paper is devoted to a detailed discussion of the problem. It is shown that the problem is of great importance in the theory of the structure of the atom.

The fifth part of the paper is devoted to a detailed discussion of the problem. It is shown that the problem is of great importance in the theory of the structure of the atom. The sixth part of the paper is devoted to a detailed discussion of the problem. It is shown that the problem is of great importance in the theory of the structure of the atom.



90 26646

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Joan M. Fyock</i>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>9 14 90</i>  |  | 3. TIME OF DEATH<br><i>10:15 A M</i>  |   |
| 4. SOCIAL SECURITY NUMBER<br><i>59-439757</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>58</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>4-7-32</i>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Washington, DC</i>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Holy Cross Hospital</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Silver Spring MD</i>                                  |   |
| 9c. COUNTY OF DEATH<br><i>Montgomery</i>   |  |   |  | RESIDENCE OF DECEDENT   |  |   |   |
| 10a. STATE<br><i>MD</i>  |  | 10b. COUNTY<br><i>Montgomery</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Silver Spring</i>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><i>14804 Maydale Court</i>   |  |   |  | 10f. ZIP CODE<br><i>20905</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                         |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>1-12</i><br>College (1-4 or 5+) <i>2 years</i>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Dog Grooming</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Self Employed</i>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Charles B. Good</i>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Selma E. Miller</i>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>John Calvin Fyock</i>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>14804 Maydale Court, Silver Spring, Md. 20905</i>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Gate of Heaven Cemetery</i>  |  | 20c. LOCATION — City or Town, State<br><i>Silver Spring, Md.</i>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Clark E. Wilson</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Hines/Rinaldi Funeral Home<br/>11800 N.H. Ave., Silver Spring, Md. 20904</i>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic Malignant Melanoma</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br><i>Months</i>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>cutaneous melanoma</i>  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>   |   |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dr. Abraham Danish</i>   |  |   |  | 29c. LICENSE NUMBER<br><i>D04189</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9/14/90</i>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Dr. Abraham Danish 1106 Spring St.S.S.Md.</i>  |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><i>SEP 17 '90</i>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



REG. NO.

DHMH-1A Rev 1/89

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

1942. 31

90 26648

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HOWARD A. SEBELEIN</b>  |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>5</b> YEAR <b>90</b>                                     |  | 3. TIME OF DEATH<br><b>7:30 A.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-24-4838</b>  |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>62</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 25, 1928</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b>   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Annapolis</b>  |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Annapolis</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>8 McKendree Avenue</b>  |  |  |  | 10f. ZIP CODE<br><b>21401</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |
| 11. MARITAL STATUS<br><b>2</b> <input checked="" type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>W W II</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>12</b> Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Owner</b>  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Upholstery Company</b>                |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Andrew Gebelein</b>  |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rosa Mueller</b>                           |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Louise B. Gebelein</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8 McKendree Avenue, Annapolis, MD 21401</b>   |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Anne's Cemetery</b>  |  |  | 20c. LOCATION — City or Town, State<br><b>Annapolis, MD</b>                |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert S. Taylor</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Taylor Funeral Chapel 21401<br/>147 Gloucester St., Annapolis, MD</b>  |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <b>Sudden Cardiac Death</b>   |  |   |  |  |  | Approximate interval between Onset and Death<br><b>instant.</b>  |  |
|  |  | b. <b>Ventricular fibrillation</b>   |  |   |  |  |  | <b>instant</b>   |  |
|  |  | c. <b>Arteriosclerotic cardiomyopathy</b>  |  |   |  |  |  | <b>years</b>   |  |
|  |  | d.   |  |   |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Atrial Fibrillation</b><br><b>Pulm. Emphysema.</b>  |  |  |  |   |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO                          |  |   |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  | HOSPITAL:<br><b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA                                     |  | OTHER:<br><b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)  |  | 26. PLACE OF DEATH (Check only one)  |  |  |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide <b>5</b> <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                       |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Peter F. Verkoyan MD</b>   |  |  |  |   |  | 29c. LICENSE NUMBER<br><b>D11653</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-5-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>PETER F. VERKOYAN 1833 FOREST Dr. Annapolis Md 21401</b>   |  |  |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 11 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendell</b>  |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26649

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Gretchen S. Gardiner</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 12 90</b>   |  | 3. TIME OF DEATH<br><b>4:45 p.m.</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>168 12 1603</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>4 30 1912</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Annapolis</b>  |   |
| 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>  |  |  |  | 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Anne Arundel</b>   |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Annapolis</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>142 Georgetown Road</b>   |   |
| 10f. ZIP CODE<br><b>21403</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>2</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Norris A. Scott</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Frances G. Taylor</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>N. Scott Gardiner</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>204 Mill Harbor Dr. Arnold, Md. 21012</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Alexandria, Va.</b>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Donald S. Taylor</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Taylor Funeral Chapel Annapolis, Md.</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RESPIRATORY ARREST</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>INVASIVE HEAD NECK CARCINOMA</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><b>TOBACCO USE</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>d. <b>TOBACCO USE</b> |  |  |  |  |  |  | Approximate interval Between Onset and Death<br><b>MONTHS</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |   |
| 28a. DATE OF INJURY (Month, Day, Year)  |  |  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John Davidson</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>33757</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-12-90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CHARLES A. SAGGER MD 269 PGMIN FARM RD ANNOLIS</b>  |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 13 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26650

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>MABEL J GEISS</u>   |  |  |  | 2. DATE OF DEATH<br>MONTH <u>9</u> DAY <u>18</u> YEAR <u>90</u>  |  | 3. TIME OF DEATH<br><u>1820</u> <u>P</u>   |  |
| 4. SOCIAL SECURITY NUMBER<br><u>216-46-7975</u>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><u>90</u> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>10-30-99</u>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>New Jersey</u>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><u>Baltimore County General Hospital</u>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Randallstown</u>   |  |
| 9c. COUNTY OF DEATH<br><u>Baltimore County</u>   |  |  |  | 10a. STATE<br><u>Maryland</u>  |  | 10b. COUNTY<br><u>Carroll County</u>   |  |
| 10c. CITY, TOWN OR LOCATION<br><u>Sykesville</u>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><u>7200 Third Avenue (Fairhaven)</u>   |  |
| 10f. ZIP CODE<br><u>21784</u>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>White</u>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Homemaker</u>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Domestic</u>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>William David Muir</u>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Anna Yeager</u>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Fairhaven</u>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>7200 Third Avenue Sykesville, MD 21784</u>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <u>Entombment</u>  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Lorraine Park Mausoleum</u>   |  | 20c. LOCATION — City or Town, State<br><u>Baltimore, MD</u>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Brian L. Haight</u>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>HAIGHT FUNERAL HOME (P.O. Box 195)<br/>Sykesville, MD 21784 (301) 795-1400</u>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |  |  |  |  |
| a. <u>Ventricular fibrillation</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>SEIZURE</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u>BRADYCARDIA (SEVERE) AND</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <u>HYPOTENSION</u><br>AND <u>PERMANENT PACEMAKER IMPLANTATION</u>  |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>SEVERE CORONARY ARTERIAL DISEASE</u>  |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 7 <input checked="" type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><u>M</u>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Joseph M. Reilly MD</u>  |  |  |  | 29c. LICENSE NUMBER<br><u>D29302</u>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>9-18-90</u>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>JOSEPH M. Reilly 8600 LIBERTY RD Randallstown, MD 21133</u>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><u>SEP 20 '90</u>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26651

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Anna Grace Golden</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>September 13, 1990</i>   |  | 3. TIME OF DEATH<br><i>6:50 P</i>  |   |
| 4. SOCIAL SECURITY NUMBER<br><i>217-32-5693-D</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>81</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>March 24, 1909</i>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Washington County Hospital</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Hagerstown</i>   |   |
| 9c. COUNTY OF DEATH<br><i>Washington</i>   |  |  |  | 10a. STATE<br><i>Maryland</i>   |  | 10b. COUNTY<br><i>Washington</i>   |   |
| 10c. CITY, TOWN OR LOCATION<br><i>Hagerstown</i>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><i>750 Dual Highway</i>  |   |
| 10f. ZIP CODE<br><i>21740</i>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>unknown</i> College (1-4 or 5+) <i>unknown</i>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Homemaker</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Perry Edward Stottemyer</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Clara Elizabeth Sipes</i>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Ernie Golden</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>6125 Sensel Road Hancock, Maryland 21750</i>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Warfordsburg Presbyterian Cemet.</i>   |  | 20c. LOCATION — City or Town, State<br><i>Warfordsburg, Pa. 17267</i>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Grove Funeral Home<br/>141 West Main St. Hancock, Md. 21750</i>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Lung Cancer</i><br>a. DUE TO (OR AS A CONSEQUENCE OF): <i>Chronic Obstructive Pulmonary Disease</i><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Liver Disease</i>   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>1000001</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9-14-90</i>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Evaristo E. Lopez Lopez 587 E. 1st St. Hagerstown, Md. 21740</i>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><i>SEP 25 '90</i>   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

James M. Smith

1872

90 26652

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Daisy Marie GEARHART</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 24, 1990</b>   |  | 3. TIME OF DEATH<br><b>M</b>  |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>66</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>June 16, 1924</b>                                  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington County Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>  |  | 9c. COUNTY OF DEATH<br><b>Washington</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  |   |  | 10b. COUNTY<br><b>Washington</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Boonsboro</b>   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br><b>17836 Bakersville Road</b>   |  |   |  |
| 10f. ZIP CODE<br><b>21713</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b><br>College (1-4 or 5+) <b>— — —</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>housewife</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George W. Duvall</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Mound</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lloyd W. Gearhart, Sr.</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17836 Bakersville Rd., Boonsboro, Md. 21713</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rose Hill Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Hagerstown, Maryland</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Scott Minnich</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MINNICH FUNERAL HOME<br/>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | <b>Metastatic Carcinoma of Cervix</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Bilateral Hydrocephalus</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Intestinal obstruction</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Aneurysm of Chronic Disease</b><br>d.                       |  |   |  |   |  |
| Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Frozen Bladder Secondary to radiation</b><br><b>Urosepsis</b>   |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature] M.D.</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D35487</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/24/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>T. PASHA M.D. 376 MILL ST. Hagerstown MD 21740</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 25 '90</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26653

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MATILDE GARCIA</b>  |  |  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> - DAY <b>13</b> - YEAR <b>90</b>               |  | 3. TIME OF DEATH<br><b>11:05P. M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>263-51-9654</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>93</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>JAN. 2, 1897</b>                     |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>CUBA</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>HOLY CROSS HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SILVER SPRING</b>  |  |   | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>SILVER SPRING</b>  |  |   | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br><b>2303 GREENERY LANE</b>  |  |  |  | 10f. ZIP CODE<br><b>20906</b>  |  |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>CUBA</b>   |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: <b>CUBAN</b> |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>HOMEMAKER</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  |   | 16b. KIND OF BUSINESS/INDUSTRY   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>VICTOR de la Noval</b>   |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rosa Rivero</b>           |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jose Garcia (Son)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2303 Greenery Lane, Silver Spring, Maryland 20906</b>  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GATE OF HEAVEN CEMETERY</b>   |  |   | 20c. LOCATION — City or Town, State<br><b>SILVER SPRING, MARYLAND</b>                    |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W., SIL.SP., MD 20901</b>   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CONGESTIVE HEART FAILURE</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">{</div> <div> <p>a. DUE TO (OR AS A CONSEQUENCE OF): <b>TRICUSPID REGURGITATION</b></p> <p>b. DUE TO (OR AS A CONSEQUENCE OF): <b>PULMONARY FIBROSIS</b></p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d.</p> </div> </div> |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  |  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY M  |  | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)      |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Hector K. Collison</b>   |  |  |  |  |  | 29c. LICENSE NUMBER<br><b>02625</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/14/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>HECTOR K. COLLISON, M.D. 1111 SPRING STREET SILVER SPRING, MARYLAND 20910</b>  |  |  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 17 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26654

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |  |  |   |  |   |  |  |  |
|--|--|---|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Melvin Morris Gusdorf, Jr.   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 13 1990  |  |  |  | 3. TIME OF DEATH<br>5:45 A M  |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>579-32-8343   |  |   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>63 YRS.                          |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Apr. 18 1927  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Wash., DC   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>8205 Wahly Dr.   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Beth.   |  |  |  | 9c. COUNTY OF DEATH<br>Montgomery   |  |   |  |  |  |
| RESIDENCE OF DECEDENT  |  |   |  |  |  |  |  |   |  |   |  |  |  |
| 10a. STATE<br>MD   |  | 10b. COUNTY<br>Montgomery   |  | 10c. CITY, TOWN OR LOCATION<br>Bethesda  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>8205 Wahly Drive   |  |   |  | 10f. ZIP CODE<br>20017   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW II - Korea |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>3   |  |   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Business Executive  |  |  |  | 15b. KIND OF BUSINESS/INDUSTRY<br>Marking Devices   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Melvin M. Gusdorf, Sr.  |  |   |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Pauline Cohen |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Betty Gusdorf  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same as item # 10   |  |  |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Wash. Hebrew Cong. Mem. Pk. Cem.   |  |  |  | 20c. LOCATION — City or Town, State<br>Wash., DC  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Michael S. Nelson   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Joseph Gawler's Sons, Inc.<br>5130 WI Ave. NW Wash., DC 20016  |  |  |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pancreatic Cancer<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
|  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Peter B. Sherer MD  |  |   |  |  |  | 29c. LICENSE NUMBER<br>D 21910                                     |  |   | 29d. DATE SIGNED (Month, Day, Year)<br>Sept. 13 1990 |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>3947 Ferrara Dr. Wheaton, Md. 20906 Peter Sherer  |  |   |  |  |  |  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 14 '90  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |  |   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20

100 102

90 26655

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |  |  |  |  |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>Annie Grauel</b>  |  |   |  | AKA ANNIE JACQUELINE GRAUEL<br>AKA ANNIE PITTMAN GRAUEL   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9/10/90</b>                                 |  | 3. TIME OF DEATH<br><b>9:35 P.M.</b>                     |  |
| 4. SOCIAL SECURITY NUMBER<br><b>416-28-3789</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>67</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>9/11/22</b> |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>ALABAMA</b>   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Southern Maryland Hosp Ctr</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Clinton</b>                                |  | 9c. COUNTY OF DEATH<br><b>P.g</b>                        |  |
| RESIDENCE OF DECEASED  |  |   |  |   |  |  |  |  |  |  |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>PRINCE GEORGES</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BRANDYWINE</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |
| 10e. STREET AND NUMBER<br><b>10505 CEDARVILLE ROAD, #5-9</b>   |  |   |  | 10f. ZIP CODE<br><b>20613</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEASED EVER IN U.S. ARMY FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>              |  |  |  |
| 15. DECEASED'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>  |  |   |  | 16a. DECEASED'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>GROVER CLIFTON DOWNING</b>   |  |   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>NORA GAMBLE</b>  |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARJORIE GERHOLD (DAUGHTER)</b>   |  |   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3614 GRANITE ROAD, WOODSTOCK, MARYLAND 21163</b> |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CEDAR HILL CEMETERY</b>  |  |  |  | 20c. LOCATION — City or Town, State<br><b>SUITLAND, MARYLAND</b>                     |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W., SIL.SP., MD 2091</b>                      |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardio-pulmonary Arrest</b>  |  |   |  |   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |  |  |  |  |  |  |
| b. <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b>   |  |   |  |   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |  |  |  |  |  |  |
| c. <b></b>   |  |   |  |   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |  |  |  |  |  |  |
| d. <b></b>   |  |   |  |   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Linda Whitty MD</b>  |  |   |  |   |  | 29c. LICENSE NUMBER<br><b>D17162</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/11/90</b>                                |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Linda Whitty MD 9556 CEAN Hwy Upper Marlboro, MD 20782</b>   |  |   |  |   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 17 '90</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |  |  |  |  |

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



90 26656

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Mary C. Geary</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>9</i> DAY <i>13</i> YEAR <i>90</i>   |  | 3. TIME OF DEATH<br><i>9 A M</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br>324-14-8971   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>78</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Oct. 22, 1911   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Suburban Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Bethesda   |  | 9c. COUNTY OF DEATH<br>Montgomery   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Montgomery  |  | 10c. CITY, TOWN OR LOCATION<br>Chevy Chase  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>5480 Wisconsin Avenue  |  |  |  | 10f. ZIP CODE<br>20815  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i><br>College (1-4 or 5+) <i>College</i>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Clerk</i>                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>U.S. Government</i>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>William G. Craig</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Mable Childress</i>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Charles W. Foster, Esq.</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>20814<br/>4550 Montgomery Avenue, Suite 330N, Bethesda, MD</i>                              |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Mt. Carmel Cemetery</i>   |  | 20c. LOCATION — City or Town, State<br><i>Hillside, Illinois</i>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Doyle C. Daniel</i> M00522   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Robert A. Pumphrey Funeral Home<br/>Bethesda-Chevy Chase, Inc., 7557 Wisconsin<br/>Avenue, Bethesda, Maryland 20814-3501</i>                             |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><i>Staphylococcus Aureus Sepsis</i><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>Chronic Renal Failure</i><br><i>Acute Renal Failure</i><br><i>Acute Respiratory Failure</i> |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><i>2 weeks</i><br><i>years</i><br><i>2 weeks</i><br><i>2 weeks</i>                                 |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Atherosclerotic Heart Disease</i><br><i>Congestive Heart Failure</i><br><i>Ventricular Tachycardia + Fibrillation</i>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. Blaine Fitzgerald, M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>D0-1948</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>09/13/90</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>J. Blaine Fitzgerald, M.D., 8218 Wisconsin Avenue, Bethesda, Maryland 20814</i>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>SEP 17 '90</i>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the paper is devoted to a discussion of the general principles of the theory of the structure of the atom. It is shown that the structure of the atom is determined by the laws of quantum mechanics, and that the laws of quantum mechanics are in agreement with the experimental facts.

2. The second part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of the elements of the periodic table. It is shown that the theory of the structure of the atom is in agreement with the experimental facts.

3. The third part of the paper is devoted to a discussion of the application of the theory of the structure of the atom to the study of the properties of the elements of the periodic table. It is shown that the theory of the structure of the atom is in agreement with the experimental facts.

90 26657

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ophelia IOLA Hodshon</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>9</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>2109</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-024490</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>10/10/11</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>VA</b>  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Home</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Glen Burnie</b>  |  | 9c. COUNTY OF DEATH<br><b>AA.</b>   |  |
| 10a. STATE<br><b>MD</b>  |  |  |  | 10b. COUNTY<br><b>AA.</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Glen Burnie</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>7871 Americana Cir #201</b>   |  | 10f. ZIP CODE<br><b>21061</b>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>MOSES L. PATRICK CARNELL</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bette J. Clemons</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ernest Hodshon</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>107 Milburn Circle, Pasadena, MD 21122</b> |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metrol Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Croftsville, MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Robert D. [Signature]</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>BARRANCO &amp; SONS Severna Park</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Myocardial Infarction</b>   |  |  |  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |  |  |   |  |
| b. <b>INFLUENZA Syndrome</b>   |  |  |  |  |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
|  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>William P. Jones, MD Deputy</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D06054</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/10/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>William P. Jones, MD 695 America 21035</b>   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 11 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Hudson-Rodell</b>  |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11/11/51

11/11/51 (over)



90 26658

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Margit Horwitz</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09-11-90</b>   |  | 3. TIME OF DEATH<br>M<br><b>7:58p</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>090-10-2627</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>08-07-16</b>  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Pleasant Living Conv. Center</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Edgewater</b>   |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>  |   |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |   |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Edgewater</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>144 Washington Street</b>  |  |  |  | 10f. ZIP CODE<br><b>21037</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>6</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Meter Maid</b>               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>City Government</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Josef Szabo</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Esther Papp</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Alexander Horwitz</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3091 Sussex Place, Riva, MD 21140</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hardesty Funeral Home P.A.<br/>12 Ridgely Avenue, Annapolis, MD</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Ca of VULVA</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><div style="display: flex; justify-content: space-between;"> <div style="width: 30%;">         a. DUE TO (OR AS A CONSEQUENCE OF):<br/><br/>         b. DUE TO (OR AS A CONSEQUENCE OF):<br/><br/>         c. DUE TO (OR AS A CONSEQUENCE OF):<br/><br/>         d.       </div> <div style="width: 60%; border-left: 1px solid black; padding-left: 10px;">         Approximate Interval Between Onset and Death       </div> </div> |  |  |  |   |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)   |  |  |  |   |  |   |   |
| HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA   |  | OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |   |
|   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>005458</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/12/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>HARVEY STEINBERG 6131 SHADYSIDE RD. SHADYSIDE MD 20764</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEPT 13 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26659

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HAWKINS, William WILLIAM HAWKINS</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 12 90</b>   |  | 3. TIME OF DEATH<br><b>1050 M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>213-22-2411</b>  |  | 5. SEX<br><b>1</b> <input type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>12/8/18</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>ANNE ARUNDEL MEDICAL CENTER</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ANNAPOLIS MD</b>   |   |
| 9c. COUNTY OF DEATH<br><b>AA</b>   |  |   |  | RESIDENCE OF DECEDENT   |  |  |   |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>ANNE ARUNDEL</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>ANNAPOLIS</b>   |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>422 CHESAPEAKE AVENUE</b>   |  |   |  | 10f. ZIP CODE<br><b>21403</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 11. MARITAL STATUS<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                             |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>DELIVERY MAN</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>WALTER LEAR'S FURNITURE</b>  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HENRY HAWKINS</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LOUCRECY MURDOCK</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>REBECCA GILCREST</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>422 CHESAPEAKE AVE. ANNAPOLIS, MD. 21403</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>PINELAWN MEM. PARK</b>   |  | 20c. LOCATION — City or Town, State<br><b>ANNAPOLIS, MD.</b>  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Larry H. Reese</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>821 WEST ST. ANNAPOLIS MD: 21401</b><br><b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>myocardial infarction</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>Arteriosclerosis</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  |
|  |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  | 25. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input checked="" type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>7</b> <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO     |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                           |   |
| 29a. CERTIFIER<br>(Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Donna C. Roane, M.D.</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>810698</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/12/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Donna C. Roane M.D. 1616 Forest Drive ANNAPOLIS 21403</b>  |  |   |  |   |  |  |   |
| 31. DATE FILED<br><b>SEP 14 1990</b>   |  |   |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Robbin L. Bassett Hill  |  |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 14 YEAR 90  |  | 3. TIME OF DEATH<br>11:55 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>216-94-0071  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>24 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>April 2 1966   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>MD. Rt. 354  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Powellville  |  | 9c. COUNTY OF DEATH<br>Wicomico   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Worcester   |  | 10c. CITY, TOWN OR LOCATION<br>Berlin   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>9716 Goody Hill Road  |  | 10f. ZIP CODE<br>21811   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Grower   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Poultry   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Robert J. Bassett  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Connie Lynch   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Robert J. Bassett   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9716 Goody Hill Road, Berlin, Maryland 21811   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Bassett Family Cemetery  |  | 20c. LOCATION — City or Town, State<br>Berlin, Maryland   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Charles W. Hasky   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Hastings Funeral Home<br>Selbyville, DE 19975   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple injuries<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
|   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br>9/14/90  |  | 28b. TIME OF INJURY<br>11 P M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
|   |  | 28d. DESCRIBE NOW INJURY OCCURRED<br>impacts Driver in truck/fixed objects   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>MD.Rt.354, Powellville,MD   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Frank J. Peretti, M.D. - Assistant  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/15/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Frank J. Peretti, M.D. - Assistant 111 Penn St. Balto.MD. ss   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 17 90  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26661

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Donis E. Hale</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>September 5 1990</i>   |  | 3. TIME OF DEATH<br><i>1228</i> M   |   |
| 4. SOCIAL SECURITY NUMBER<br><i>216-20-1514</i>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><i>63</i> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><i>5-5-27</i>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>Md.</i>  |   |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><i>Peninsula General Hospital</i>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Salisbury</i>   |  | 9c. COUNTY OF DEATH<br><i>Wicomico</i>  |   |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |   |
| 10a. STATE<br><i>Md.</i>  |  | 10b. COUNTY<br><i>Worcester</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Berlin</i>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><i>37 Lake Haven</i>  |  |  |  | 10f. ZIP CODE<br><i>21811</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                             |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i><br>College (1-4 or 5+) <i>At Home</i>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>At Home</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Lawrence Behn</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Myrtle Langdon</i>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>James C. Hale</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>37 Lake Haven Berlin, Md., 21811</i>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Salisbury Crematory</i>   |  | 20c. LOCATION — City or Town, State<br><i>Salisbury, Md.</i>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John A. Ullrich</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Ullrich Funeral Home Berlin, Md.</i>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Serious Pneumonia</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY M   |   |
| 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Eddie Valenzuela MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>040190</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9/6/90</i>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Eddie Valenzuela MD Rt 5 Box 473 S, Salisbury, Md 21801</i>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><i>SEP 10 1990</i>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26662

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BABY BOY HURLEY</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>08 27 1990</b>  |  | 3. TIME OF DEATH<br><b>9:00 P M</b>  |   |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>0826 1990</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>BALTIMORE COUNTY</b>                      |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>G.B.M.C.-6701 N. CHARLES ST</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE MD 21204</b>   |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b>   |   |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>HARFORD COUNTY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>BEL AIR</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>803 E BROADWAY</b>  |  |  |  | 10f. ZIP CODE<br><b>21014</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?  |   |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>               |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOSEPH HURLEY</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SUSAN ENGQUIST</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | 20c. LOCATION — City or Town, State  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>GBMC; 6701 N. Charles St; Towson, MD 21204</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| a. <u>CARDIO-RESPIRATORY FAILURE</u><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |   |
| b. <u>RESPIRATORY DISTRESS SYNDROME</u><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |   |
| c. <u>PNEUMONPERITONEUM, IMMATURITY</u><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |   |
| d.   |  |  |  |  |  |  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |   |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO     |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)             |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                        |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>D27740</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/28/90</b>                                    |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Robert A. Palermo, M.D.; GBMC - 6701 N. Charles Street; Towson, MD 21204</b>   |  |  |  |  |  |  |   |
| 31. DATE FILED<br><b>SEP 27 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26663

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><del>Megan K. Hiers</del> <b>MEGAN KERRIGAN HIERS</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>11</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>04:25 A M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>NONE ISSUED</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>YRS. MONTHS DAYS <b>38</b>  |  | 7. DATE OF BIRTH<br>(Month, Day, Year) <b>08/04/1990</b>                             |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>DORCHESTER GENERAL HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CAMBRIDGE</b>   |  | 9c. COUNTY OF DEATH<br><b>DORCHESTER</b>   |   |
| 10a. STATE<br><b>MARYLAND</b>   |  |  |  | 10b. COUNTY<br><b>DORCHESTER</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>TAYLORS ISLAND</b>                                 |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  |   |
| 10e. STREET AND NUMBER<br><b>P.O. BOX 265</b>   |  |  |  | 10f. ZIP CODE<br><b>21669</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |   |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE/CAUC.</b>     |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> College (1-4 or 6+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>NEVER EMPLOYEED</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>NEVER EMPLOYEED</b>  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>RANDALL H. HIERS</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>KATHLEEN A. COPPINGER</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print) (FATHER)<br><b>DR. RANDALL H. HIERS</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. BOX 265, TAYLORS ISLAND, MD. 21669</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>OLD TRINITY CHURCH CEMETERY CHURCH CREEK, MD.</b>   |  | 20c. LOCATION — City or Town, State   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Colleen Curran-Bromwell</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>CURRAN FUNERAL HOME<br/>308 HIGH ST., CAMBRIDGE, MD. 21613</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Cardiac Arrest</b><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <b>Cardiac Arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Congenital Heart Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                   |
|   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Leigh Johnson M.D.</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>034598</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-11-90</b>                                |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Leigh Johnson, M.D. 503 Byrn Street Cambridge, MD 21613</b>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 14 '90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26664

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Howard W. Hornbaker</i>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 22, 1990  |  | 3. TIME OF DEATH<br>3:12 A. M.  |   |
| 4. SOCIAL SECURITY NUMBER<br>215-14-2314  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>68 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Sept 10, 1922                               |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Washington County Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown                                     |   |
| 9c. COUNTY OF DEATH<br>Washington   |  |   |  | 10a. STATE<br>Maryland  |  |   |   |
| 10b. COUNTY<br>Washington   |  |   |  | 10c. CITY, TOWN OR LOCATION<br>Hagerstown   |  |   |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br>717 George Street   |  |   |   |
| 10f. ZIP CODE<br>21740  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW II   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                   |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Gas Attendant  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Service Station   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Edgar Hornbaker  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Gladys Irene Haines  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>June V. Hornbaker   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>717 George Street, Hagerstown, Maryland 21740  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Greenlawn Memorial Park   |  | 20c. LOCATION — City or Town, State<br>Williamsport, Wash., Md.   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>R. Keel Brady</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Andrew K. Coffman Funeral Home, Inc.<br>40 E. Antietam St., Hagerstown, Md. 21740   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><i>Acute Bronchitis</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>Chronic Obstructive Pulmonary Disease</i> |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Chronic Myeloid Leukemia</i>   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)          |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |
| 29c. LICENSE NUMBER<br>D21457   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/23/90  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>ABDUL WAHED, MD - 1610 - OAK HILL AVE - HAGERSTOWN - MD 21740  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 24 '90   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26665

FOR  
STATE  
REGISTRAR **Ned Victor Horne** **STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH** REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ned Victor Horne</b>  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>24</b> YEAR <b>1990</b>  |  | 3. TIME OF DEATH<br><b>13:15</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>180-14-5122</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>68</b> YRS.  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>April 1, 1922</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Ringtown, Pa.</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington County Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>   |  | 9c. COUNTY OF DEATH<br><b>Washington</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Washington</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Boonsboro</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>8403 Mountain Laurel Rd.</b>  |  | 10f. ZIP CODE<br><b>21713</b>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>W. W. Two</b> |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br><b>White</b>   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Sheet Metal Foreman</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Heating &amp; Airconditing Mfg.</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Guy Victor Horne</b>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jeanette Eva Frye</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Barbara E. Horne</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8403 Mountain Laurel Rd., Boonsboro, Md. 21713</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Smithsburg Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Smithsburg, Md.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>John H. Bast, Jr.</b>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>7606 Boonsboro Pike<br/>BAST FUNERAL HOME, Boonsboro, Md. 21713</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial Infarction</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Coronary Artery Disease</b><br><b>Arteriosclerosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   | Approximate Interval Between Onset and Death<br><b>5m</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Kidney Disease</b>  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
|  |  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John H. Bast, Jr.</b>  |  | 29c. LICENSE NUMBER<br><b>D09930</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/21/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>L. L. Packer M. D. 145 West Washington St., Hagerstown, Md. 21740</b>  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 24 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26666

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Wm</i> William Vernon Hovermale   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>9</i> DAY <i>18</i> YEAR <i>90</i>   |  | 3. TIME OF DEATH<br>M   |  |
| 4. SOCIAL SECURITY NUMBER<br>232-26-7903   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F         |  | 6. AGE (In yrs. last birthday)<br>67 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>May 9, 1923   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>West Virginia  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Washington County Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown   |  |
| 9c. COUNTY OF DEATH<br>Washington  |  |  |  | 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Washington   |  |
| 10c. CITY, TOWN OR LOCATION<br>Hancock   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>13320 Porters Lane  |  |
| 10f. ZIP CODE<br>21750   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Assembler  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Aircraft Manufacture  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>William McKinnley Hovermale   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Syvilla F. Marshall  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Vernon W. Hovermale  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13320 Porters Lane Hancock, Maryland 21750   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Parkhead Cemetery   |  | 20c. LOCATION — City or Town, State<br>Big Pool, Md. 21711  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Rue Schen</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Grove Funeral Home<br>141 W. Main Street Hancock, Maryland 21750  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <i>Coronary Heart Failure</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Chronic Aortic Stenosis</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>Post Aortic Valve Replacement Dysfunction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  | Approximate interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Peripheral Aortic aneurysm</i><br><i>possible Pulmonary embolus</i>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John H. Hornbaker, Jr.</i>   |  |  |  | 29c. LICENSE NUMBER<br>007885   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-18-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>John H. Hornbaker, Jr. 384 Mill St. Hagerstown MD 21740   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 25 '90  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten text at the bottom center, possibly a signature or date.

Handwritten text at the bottom right, possibly a date or initials.

90 26667

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>JOYCE S. Holland   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>August 31 1990  |  | 3. TIME OF DEATH<br>4:30 a.m.  |   |
| 4. SOCIAL SECURITY NUMBER<br>218-07-7735   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>70 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>June 17, 1920                              |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Peninsula General Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Salisbury                                     |   |
| 9c. COUNTY OF DEATH<br>Wicomico  |  |  |  | 10a. STATE<br>Maryland  |  |  |   |
| 10b. COUNTY<br>Somerset  |  |  |  | 10c. CITY, TOWN OR LOCATION<br>Crisfield, MD  |  |  |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br>3 Potomac Street  |  |  |   |
| 10f. ZIP CODE<br>21817   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>H.S. Graduate   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Sales Lady                      |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Apparel Store   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Gordon Sterling   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Margaret Ward  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>William J. Holland   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same as 10 a,b,c,d,e,f   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Sunnyridge Memorial Park   |  | 20c. LOCATION — City or Town, State<br>Crisfield, MD  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert H. Bradshaw Jr.</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Bradshaw & Sons Funeral Home<br>306 W. Main St. - Crisfield, MD 21817   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Cardio-respiratory Failure<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Cirrhotic Liver Disease.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>azotemia   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Ignatius L. D. Nardo</i>   |  |  |  | 29c. LICENSE NUMBER<br>D31546   |  | 29d. DATE SIGNED (Month, Day, Year)<br>8/31/90                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Ignatius L. D. Nardo ; P.O. Box 640, Princess Anne, MD 21853</i>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP - 6 '90   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

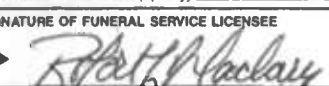


IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26668

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HEDWIG HERBECK M. HERBECK</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPT 12 1990</b>   |  | 3. TIME OF DEATH<br><b>8:50 P M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>212-10-4233</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JUNE 16, 1913</b>                              |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MONTGOMERY GENERAL HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>OLNEY</b>   |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |   |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>ROCKVILLE</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>14302 BARKWOOD DRIVE</b>  |  |  |  | 10f. ZIP CODE<br><b>20853</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>               |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b><br>College (1-4 or 5+) <b>HOMEMAKER</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>AUGUST LABER</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>THEODORA SCHAFSTEIN</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JOHN J. HERBECK (HUSBAND)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14302 BARKWOOD DRIVE, ROCKVILLE, MARYLAND 20853</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>METROPOLITAN CREMATORY</b>  |  | 20c. LOCATION — City or Town, State<br><b>ALEXANDRIA, VIRGINIA</b>  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W., SIL.SP., MD 20901</b>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Lung Carcinoma</b>   |  |  |  |   |  |  |   |
| Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |  |   |
| b. <b>Bilateral Pulmonary Effusions</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |   |
| c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>   |  |  |  |   |  |  |   |
| d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b>   |  |  |  |   |  |  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |   |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO     |   |
|  |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE HOW INJURY OCCURED  |  |  |   |
|  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>D32817</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/13/90</b>                                    |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>M. W. Khan MD 12016 Georgia Ave, Wheaton, MD 20902</b>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 17 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial certificate. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26669

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Charles Hall McCamey</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 14 90</b>  |  | 3. TIME OF DEATH<br><b>11:15 AM</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>215-14-7332</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Dec. 31, 1920</b>                   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Ohio</b>   |  |  |  |   |  |  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Prince Frederick</b>  |  | 9c. COUNTY OF DEATH<br><b>Calvert</b>  |   |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Calvert</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Lusby</b>                                      |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |  |   |
| 10e. STREET AND NUMBER<br><b>P.O. Box 324</b>   |  |  |  | 10f. ZIP CODE<br><b>20657</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                      |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>          |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>1-12</b><br>College (1-4 or 5+) <b>2 years</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Electronics</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>US Government</b>  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frank S. McCamey</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Flora G. Hall</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ruth Vivian McCamey</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>PO Box 324, Lusby, Md. 20657</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Fort Lincoln Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Brentwood, Md.</b>  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Clark E. Wilson</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hines/Rinaldi Funeral Home</b><br><b>11800 N.H. Ave., Silver Spring, Md. 20904</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. acute extension m-i.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Cardiac arrest.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Diabetes + CAD.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. My Persten S. in</b> |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
|   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |  |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Kumara Yazdani</i>   |  | 29c. LICENSE NUMBER<br><b>D17165</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/15/90</b>                            |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. K. Yazdani Prince Frederick, Maryland 20678</b>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 17 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21202-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or funeral home for 72 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as an internal transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26670

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOSEF GEORG HEEG</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPT. 10, 1990</b>   |  | 3. TIME OF DEATH<br><b>11:55 A. M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>579-50-1659</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>APRIL 20, 1913</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>2416 ECCLESTON STREET</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SILVER SPRING</b>   |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>MONTGOMERY</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>SILVER SPRING</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>2416 ECCLESTON STREET</b>  |  |   |  | 10f. ZIP CODE<br><b>20902</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>12</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>SANITARY STEAM ENGINEER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>PUBLISHER</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>MAXIMILIAN LORENZ HEEG</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>PHILIPPINE HEFTER</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ELISABETH C. HEEG (WIFE)</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2416 ECCLESTON STREET, SILVER SPRING, MARYLAND 20902</b>                                    |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GATE OF HEAVEN CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>SILVER SPRING, MARYLAND</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W., SIL. SP., MD 20901</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC DISEASE</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>ADENOCARCINOMAS OF THE COLON</b><br>c. <b>COLON</b><br>d. <b>COLON</b> |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 29b. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29c. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29d. SIGNATURE AND TITLE OF CERTIFIER<br><i>Joseph M. Solinas MD</i>  |  |   |  | 29e. LICENSE NUMBER<br><b>D10101</b>  |  | 29f. DATE SIGNED (Month, Day, Year)<br><b>9/10/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JOSEPH MARIA SOLINAS - 9801 GEORGIA AV. S.S. MD 20902</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>9/10/90</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26671

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |   |
|--|--|---|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>LeRoy John Hansen  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 11, 1990  |  | 3. TIME OF DEATH<br>8:25 P M   |   |
| 4. SOCIAL SECURITY NUMBER<br>395-05-1870   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>68 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>March 10, 1922                             |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br># 5 Victory Ct.  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Potomac  |  | 9c. COUNTY OF DEATH<br>Montgomery  |   |
| 10a. STATE<br>MD   |  |   |  | 10b. COUNTY<br>Montgomery   |  | 10c. CITY, TOWN OR LOCATION<br>Potomac   |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |  |   |
| 10e. STREET AND NUMBER<br>#5 Victory Court   |  |   |  | 10f. ZIP CODE<br>20854  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4+  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Foreign Editor   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Magazine  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Harry F. Hansen   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Angeline Renk  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Dane Hansen  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>#5 Victory Court, Potomac, MD 20854  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Comfort Crematory   |  | 20c. LOCATION — City or Town, State<br>Alexandria, VA   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Michael S. Nelson   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>5130 WI Ave. NW Wash., DC<br>Joseph Gawler's Sons, Inc. 20016   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused this death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma Of Prostate<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |  | Approximate interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
|  |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Jeremy V. Cooke M.D.  |  |   |  | 29c. LICENSE NUMBER<br>D 04602  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/12/90                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Jeremy V. Cooke, M.D. 10400 CT Ave, Kensington, MD 20895  |  |   |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 14 '90  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26672

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARGARET GWENNETH HATFIELD</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 14, 1990</b>  |  | 3. TIME OF DEATH<br><b>9:40 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>261-25-8283</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 8, 1918</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>England</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Medlantic Manor</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |  |  | 10a. STATE<br><b>Florida</b>   |  | 10b. COUNTY<br><b>Broward</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Pompano Beach</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>2350 N.E. 14th Street, #615</b>   |  |
| 10f. ZIP CODE<br><b>33062</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Harry Smith</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Phyllis Ruby Parker</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Susan Johnson (daughter)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12800 Teaberry Rd, Silver Spring, MD 20906</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Suburban Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Silver Spring, MD</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><br><b>MO0827</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Rapp Funeral Services, P.A.<br/>933 Gist Ave, Silver Spring, MD 20910</b>   |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Congestive Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Atherosclerosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>1 Week</b><br><b>Years</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes</b>   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 6 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>W.O. Ferris M.D.</b>   |  |  |  |
| 29c. LICENSE NUMBER<br><b>D31918</b>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Sept. 14, 1990</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Warren O. Ferris, M.D. 3701 Rossmoor Blvd, Silver Spring, MD 20906</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 17 '90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and returned to the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STAGE 03

IDEN, Ethel

90 26673

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Ethel L. Iden</i>  |  |   |  | 2. DATE OF DEATH<br>MONTH <i>09</i> DAY <i>17</i> YEAR <i>1990</i>  |  | 3. TIME OF DEATH<br><i>M</i>  |   |
| 4. SOCIAL SECURITY NUMBER<br><i>220-34-0201</i>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>100</i> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>March 4, 1890</i>             |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>West Virginia</i>  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Washington County Hospital</i>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Hagerstown</i>                |   |
| 9c. COUNTY OF DEATH<br><i>Washington</i>  |  |   |  | 10a. STATE<br><i>Maryland</i>   |  |   |   |
| 10b. COUNTY<br><i>Washington</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Hancock</i>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |   |
| 10e. STREET AND NUMBER<br><i>204 East Terrace Street</i>  |  |   |  | 10f. ZIP CODE<br><i>21750</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                             |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i> |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>Unknown</i><br>College (1-4 or 5+) <i></i>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Homemaker</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Martin Eldridge Stotler</i>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Dora Jamison</i>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Paul Iden</i>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>62 East Main Street Hancock, Maryland 21750</i>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Mt. Olivet U.M. Cemetery</i>   |  | 20c. LOCATION — City or Town, State<br><i>Berkeley Springs, WV. 25411</i>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Grove Funeral Home<br/>141 West Main Street Hancock, Md. 21750</i>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Bilateral Pneumonia</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>CHF</i> |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br><i>10 days</i><br><i>10 days</i>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>ASCD, DM</i>   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide |  |   |  |   |   |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED                                       |   |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>V. J. Smith MD</i>  |  |   |  | 29c. LICENSE NUMBER<br><i>D 18019</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9.18.90</i>                   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>VASANT DATTA, MD 334 MILL ST HAGERSTOWN, MD 21740</i>   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><i>SEP 25 '90</i>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 4, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26674

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Lewis Earl IRVING</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>21</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>1:30 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-09-6901</b>   |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>July 3, 1906</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Avalon Manor Home</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Washington</b>  |  |   |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Washington</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>Route 5, Box 324</b>   |  |
| 10f. ZIP CODE<br><b>21740</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:   |  |   |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>  |  |   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>6</b> Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>  |  |   |  |
| 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>sand blasting</b>   |  |   |  | 17. KIND OF BUSINESS/INDUSTRY<br><b>aircraft</b>  |  |   |  |
| 18. FATHER'S NAME (First, Middle, Last)<br><b>Jacob Elmer Irving</b>  |  |   |  | 19. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Leorah J. Haupt</b>   |  |   |  |
| 20. INFORMANT'S NAME (Type/Print)<br><b>Geraldine J. Irving</b>   |  |   |  | 21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Route 5, Box 324, Hagerstown, Md. 21740</b>  |  |   |  |
| 22. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |  |   |  | 23. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Rose Hill Cemetery</b>  |  |   |  |
| 24. LOCATION — City or Town, State<br><b>Hagerstown, Maryland</b>   |  |   |  | 25. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Scott Minnich</b>   |  |   |  |
| 26. NAME AND ADDRESS OF FACILITY<br><b>MINNICH FUNERAL HOME<br/>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>  |  |   |  | 27. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Respiratory failure</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Failure to thrive after surgery</b><br>b. <b>Due to (or as a consequence of):</b><br>c. <b>Due to (or as a consequence of):</b><br>d. <b>Due to (or as a consequence of):</b> |  |   |  |
| 28. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Uremia</b>   |  |   |  | 29. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  |   |  |
| 30. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  |  |   |  | 31. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  |   |  |
| 32. PLACE OF DEATH (Check only one)<br><b>HOSPITAL:</b> <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br><b>OTHER:</b> <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)  |  |   |  | 33. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide   |  |   |  |
| 34. DATE OF INJURY (Month, Day, Year)<br><b>none</b>  |  |   |  | 35. TIME OF INJURY<br><b>M</b>  |  |   |  |
| 36. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  |   |  | 37. DESCRIBE HOW INJURY OCCURRED<br><b>none</b>   |  |   |  |
| 38. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>none</b>  |  |   |  | 39. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 40. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | 41. SIGNATURE AND TITLE OF CERTIFIER<br><b>William W. Lesh M.D.</b>   |  |   |  |
| 42. LICENSE NUMBER<br><b>D05967</b>   |  |   |  | 43. DATE SIGNED (Month, Day, Year)<br><b>9-24-90</b>  |  |   |  |
| 44. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>William W. Lesh M.D. -411 Division Avenue Hagerstown, Md. 21740</b>   |  |   |  | 45. DATE FILED (Month, Day, Year)<br><b>SEP 25 '90</b>  |  |   |  |
| 46. REGISTRAR'S SIGNATURE<br><b>Julia Davidson Anderson</b>   |  |   |  | 47. REGISTRAR'S SIGNATURE   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten signature and date: 10/22/13

90 26675

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>AGNES A. JACOB</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 9, 1990</b>  |  | 3. TIME OF DEATH<br>P. M.   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>578-01-5566</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 25, 1913</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |   |  | 9. COUNTY OF DEATH<br><b>Anne Arundel</b>   |  |   |  |
| 10. FACILITY NAME (If not institution, give street and number)<br><b>Annapolis Convalescent Center</b>   |  |   |  | 11. CITY, TOWN OR LOCATION OF DEATH<br><b>Annapolis</b>   |  | 12. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Anne Arundel</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Annapolis</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>810 Monroe Street</b>   |  |   |  | 10f. ZIP CODE<br><b>21403</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |  |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b><br>College (1-4 or 5+) <b>10</b>  |  | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Theodore Christenson</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Martha R. Smith</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Martha Elizabeth Amor</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14518 Ascot Square Court, Boyds, MD 20841</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Hillcrest Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Annapolis, MD</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert L. Taylor</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Taylor Funeral Chapel 21401<br/>147 Gloucester St., Annapolis, MD</b>  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <i>Constrictive Heart failure</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Dilated Cardiomyopathy</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>Coronary Artery disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>Approximate Interval Between Onset and Death<br><i>chron. year.</i> |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Diabetes mellitus; gastrointestinal bleeding; chronic renal failure.</i>  |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  | 28g. DATE SIGNED (Month, Day, Year)<br><b>9-10-90</b>   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Peter F. Verkoew</i>  |  |   |  |
| 29c. LICENSE NUMBER<br><b>D11653</b>   |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-10-90</b>   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>PETER F. VERKOE W, 1833 FOREST DRIVE, ANNAPOLIS, MD 21401</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 11 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Burdick-Randall</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..

... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..

... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..

... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..

90 26676

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARY H JOHNSON</b>  |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>11</b> YEAR <b>90</b>                 |  | 3. TIME OF DEATH<br><b>4:30 P.M.</b>                        |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213126481</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2 6 1920</b>                           |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ANNE ARUNDEL MEDICAL CENTER</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ANNAPOLIS</b>   |  |  | 9c. COUNTY OF DEATH<br><b>ANNE ARUNDEL</b>   |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>ANNE ARUNDEL</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>ANNAPOLIS</b>   |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br><b>61 TOWN PINE COURT</b>  |  |  |  | 10f. ZIP CODE<br><b>21401</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>           |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEKEEPING</b>   |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>A.A. GENERAL HOSPITAL</b>                       |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN W. HEBRON</b>   |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ELEANOR COLBERT</b>      |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DELORES SIMPSON</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>179 HOLLY HOCK LANE ANNAPOLIS, MD. 21401</b>  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MARYLAND VETERAN CEMETERY</b>  |  |  | 20c. LOCATION — City or Town, State<br><b>CROWNSVILLE, MD.</b>                       |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Larry H. Reese</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY <b>821 WEST ST ANNAPOLIS MD. 21401</b><br><b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CA LUNG</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Age, dehydration, widespread metastasis</b>   |  |  |  |   |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                           |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)     |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Wm Dabbs M.D.</i>  |  |  |  |   |  | 29c. LICENSE NUMBER<br><b>D24768</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/12/90</b>       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>AA MC</b>  |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 14 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26677

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CHARLES MAYNARD JONES</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 16, 1990</b>   |  | 3. TIME OF DEATH<br><b>0552</b> M   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>220-12-2062</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>65</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>09-15-1925</b>  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Peninsula General Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Salisbury</b>   |  | 9c. COUNTY OF DEATH<br><b>Wicomico</b>  |   |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |   |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Wicomico</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Parsonsburg</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>Rt. 2 Box 230</b>  |  |  |  | 10f. ZIP CODE<br><b>21849</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII Navy</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>10</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Owner/Operator</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Pest Control Co.</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Robert C. Jones</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Leoda P. Hovatter</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charlotte A. Jones</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Rt. 2 Box 230 Parsonsburg, MD 21849</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Wicomico Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Salisbury, MD</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Gerald C. Brummett</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Bounds Funeral Home Salisbury, MD</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>CARDIOPULMONARY ARREST.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>CONGESTIVE HEART FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>ISCHEMIC HEART DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>INSULIN DEPENDENT DIABETES</b>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
|   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>D. Chodnicki MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>P20912</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/16/94</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dennis Chodnicki MD Locust + Quincey Sts., Salisbury Md.</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 18 90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Jane Davidson-Randall</b>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26678

1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Richard A. Jett   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>September 15 1990   |  | 3. TIME OF DEATH<br>4:15 P.M. M  |  |
| 4. SOCIAL SECURITY NUMBER<br>216-24-9726  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>60 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>October 4 1929   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>419 Sandy Hill Drive  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Ocean City  |  |
| 9c. COUNTY OF DEATH<br>Worcester  |  |  |  | 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Worcester   |  |
| 10c. CITY, TOWN OR LOCATION<br>Ocean City   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>419 Sandy Hill Drive   |  |
| 10f. ZIP CODE<br>21842  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>6-16-47 - 1-17-50  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>7  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use, retired.)<br>Social Security Administration  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Federal Government   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Jesse Jett   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anna L. Von Forthuber  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Juanita M. Jett   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9838 Stephen Decatur Hwy, Ocean City, MD 21842   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Maryland Veterans Cemetery  |  | 20c. LOCATION — City or Town, State<br>Hurlock, MD   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Hastings Funeral Home<br>Selbyville, DE 19975   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>HEPATIC FAILURE</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>CIRRHOSIS</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br>D 22996  |  | 29d. DATE SIGNED (Month, Day, Year)<br>Sept. 17, 1990  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Allen W. TUSTIN, M.D. 105 Pine Bluff Rd., Salisbury, Maryland 21801  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 17 '90   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1977 09

1977 09

1977 09

1977 09

1977 09

1977 09

1977 09

1977 09

1977 09

1977 09

1977 09

1977 09

1977 09

1977 09

90 26679

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |   |   |  |
|---|--|--|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Cleo Jones</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 15 1990</b>   |   | 3. TIME OF DEATH<br><b>02:20 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-44-6935</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>56</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>DEC. 14, 1933</b>   | 8. BIRTHPLACE (State or Foreign Country)<br><b>SOUTH CAROLINA</b> |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Physicians Memorial Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>LaPlata</b>   |   | 9c. COUNTY OF DEATH<br><b>Charles</b>   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>CHARLES</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>POMFRET</b>   |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>ROUTE 2 BOX 102, PRESTON LANE</b>  |  |  |  | 10f. ZIP CODE<br><b>20765</b>   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11TH</b><br>College (1-4 or 5+) <b>NONE</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>CASHIER</b>              |  | 16b. KIND OF BUSINESS/INDUSTRY  |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>MANUEL BROADRE</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MAMMIE WILSON</b>   |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JOHN L. JONES</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>RT. 2 BOX 102, PRESTON LANE, POMFRET, MD 20675</b>  |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MARYLAND VETERANS CEMETERY</b>                                  |  | 20c. LOCATION — City or Town, State<br><b>CHELTENHAM, MARYLAND</b>  |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Lydia C. Thornton Johnson</i><br><b>LYDIA C. THORNTON JOHNSON</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>THORNTON'S FUNERAL HOME, POMONKEY, MARYLAND</b>  |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>1. RESPIRATORY FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>2. CHRONIC FIBROTIC PULMONARY</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>3. PEPTIC ULCER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>4. MASSIVE GASTRIC BLEEDING</b><br>SARCOIDOSIS<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |   |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |   |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |   |   | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dr. G. Rath</i><br><b>DR. G. RATH</b>  |
| 29c. LICENSE NUMBER<br><b>D 23021</b>   |  |  |  |   |   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/15/90</b>  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Sanjeeb K. Mishra M.D. 7C Post Office Rd. Cenna Center</b>  |  |  |  |   |   |   | <b>Waldorf Md, 20602</b>   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 17 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Gisha Davidson-Randall</i>   |  |   |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Pages 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>John C. Johnson  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-10-90   |  | 3. TIME OF DEATH<br>11:24PM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>212-80-3633   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>28 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>12-25-61   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>University Hospital   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  |
| 9c. COUNTY OF DEATH  |  |  |  |   |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Montgomery  |  | 10c. CITY, TOWN OR LOCATION<br>Wheaton  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>3308 Floral Street   |  |  |  | 10f. ZIP CODE<br>20902  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11th College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Landscaper  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John D. Jones   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Dorothy Reddix   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Dorothy Johnson (Mother)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3308 Floral Street, Wheaton, MD 20902  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Harmony Memorial Park  |  | 20c. LOCATION — City or Town, State<br>Landover, MD   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>George R. Snowden</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Snowden Funeral Home, P.A.<br>Rockville, MD 20850   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple injuries with complications  |  |  |  |   |  |   |  |
| b. OUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |  |
| c. OUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| d. OUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |  |
| INSPECTION   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br>9-2-90   |  | 28b. TIME OF INJURY<br>5:45PM   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br>Passenger in auto/auto impact   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>Road  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>Mt. Zion Rd. & Rte. 180,<br>Frederick County, Maryland   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Margaret A. Korell</i>   |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-11-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARGARITA A. KORELL, MD 111 Penn Street, Baltimore, MD 21201  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 14 '90  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randell</i>  |  |   |  |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



90 26681

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Elizabeth Robinson Knight</u>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><u>9-12-90</u>  |  | 3. TIME OF DEATH<br><u>6:45A M</u>   |   |
| 4. SOCIAL SECURITY NUMBER<br><u>431-84-9279</u>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><u>82</u> YRS. |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>1-18-08</u> |  | 8. BIRTHPLACE (State or Foreign Country)<br><u>LA.</u>  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>Ginger Cove</u>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Annapolis, Md.</u>  |  | 9c. COUNTY OF DEATH<br><u>Anne Arundel</u>   |   |
| 10a. STATE<br><u>Maryland</u>   |  |  |  | 10b. COUNTY<br><u>Anne Arundel</u>  |  | 10c. CITY, TOWN OR LOCATION<br><u>Annapolis</u>                                      |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><u>4000 River Crescent Drive</u>  |  |  |   |
| 10f. ZIP CODE<br><u>21401</u>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>White</u>           |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>4</u> College (1-4 or 5+) <u>4</u>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Homemaker</u>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Home</u>   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Lee Elmer Robinson</u>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Elizabeth Irons</u>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Carol K. Blanchard</u>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>21401<br/>1073 Carriage Hill Parkway, Annapolis, MD</u>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Metropolitan Crematory</u>  |  | 20c. LOCATION — City or Town, State<br><u>Alexandria, VA</u>  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Charles E. Kinzer</u>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>Taylor Funeral Chapel 21401<br/>147 Gloucester St., Annapolis, MD</u>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Pneumonia</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <u>Pulmonary fibroemphysema ("COPD")</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>—</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u>—</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <u>—</u><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  | Approximate interval Between Onset and Death<br><u>2 months</u><br><u>many</u><br><u>years</u>            |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Hypertension</u><br><u>Hypothyroidism</u>  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><u>M</u>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Charles W. Kinzer</u>   |  |  |  | 29c. LICENSE NUMBER<br><u>D5928</u>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>9-12-90</u>                                |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Charles W. Kinzer, MD, 1833A Forest Drive, Annapolis, Maryland 21401</u>  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><u>SEP 13 1990</u>   |  | 32. REGISTRAR'S SIGNATURE<br><u>Alia Davidson-Rondelle</u>   |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1000

100

10

1000

100

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000



90 26682

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>George William Kline, Sr.</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>9-17-1990</i>  |  | 3. TIME OF DEATH<br><i>1736 hrs</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>220-18-2520</i>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>75</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>Jan. 27, 1915</i>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Washington County Hospital</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Hagerstown</i>   |  |   |  | 9c. COUNTY OF DEATH<br><i>Washington</i>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Washington</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Middletown</i>  |  | 10d. INSIDE CITY LIMITS<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><i>6346 Zittlestown Rd.</i>  |  |  |  | 10f. ZIP CODE<br><i>21769</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>8</i><br>College (1-4 or 5+) <i></i>  |  | 18a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Machanic</i>   |  | 18b. KIND OF BUSINESS/INDUSTRY<br><i>Auto Repair</i>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>John Calvin Kline</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Orphia L. Main</i>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Gladys R. Kline</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>6346 Zittlestown Rd. Middletown, Md, 21769</i>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Boonsboro Cemetery</i>  |  | 20c. LOCATION — City or Town, State<br><i>Boonsboro, Md. 21713</i>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John H. Bast</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>BAST FUNERAL HOME, 7606 Boonsboro Pike, Boonsboro, Md. 21713</i>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  | Approximate interval Between Onset and Death  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac arrest</i>  |  |  |  |   |  | <i>Immediate</i>  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| Sequitely flat conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |  |
| b. <i>Probable acute myocardial infarction</i>   |  |  |  |   |  | <i>Immediate</i>  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| c. <i>Arteriosclerotic cardiovascular disease</i>  |  |  |  |   |  | <i>15 years</i>   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| d.   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Richard E. Smith, M.D.</i>   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9/17/90</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Richard E. Smith, M.D. 1709 Oak Hill Ave. Hagerstown, Md 21740</i>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>SEP 20 '90</i>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26683

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HARRY SNAVLEY KOONTZ</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>23</b> YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>5:00 P</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-24-5490</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>60</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Dec. 27, 1929</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Garis Shop Road</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>  |  | 9c. COUNTY OF DEATH<br><b>WASHINGTON</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Washington</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>Garis Shop Road</b>  |  |  |  |
| 10f. ZIP CODE<br><b>21740</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b><br>College (1-4 or 5+) <b>0</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>courier</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>parcel delivery company</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Harry S. Koontz, Sr.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Pearl M. Bishop</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mary Jane Koontz</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Garis Shop Rd., Hagerstown, Md. 21740</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Lawn Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Hagerstown, Maryland</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>▶</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MINNICH FUNERAL HOME<br/>415 E. Wilson Blvd., Hagerstown, Md. 21740</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>George Milic M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D07005</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/23/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>GEORGE MILIC M.D. - 810 DOVER DR. - HAGERSTOWN, MD. 21740</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 25 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Pondell</b>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO

PHYSICS DEPARTMENT

90 26684

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Cecil Krieger</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09/08/90</b>   |  | 3. TIME OF DEATH<br><b>5:45 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-32-2111</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>01/15/15</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>New York</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Hebrew Home of Greater Wash.</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville, Md.</b>  |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>6105 Montrose Road</b>  |  |  |  | 10f. ZIP CODE<br><b>20852</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Unobtainable</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Unobtainable</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ernest Krieger (husband)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15220 Aylesbury Street, Silver Spring, MD 20904</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>King David Memorial Garden</b>  |  | 20c. LOCATION — City or Town, State<br><b>Falls Church, VA</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Danzansky-Goldberg Memorial Chapels, Inc.<br/>1170 Rockville Pike, Rockville, MD 20852</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>ALZHEIMER'S DISEASE</b>  |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HYPERTENSION</b><br><b>HISTORY OF CONGESTIVE HEART FAILURE.</b>   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> MD   |  |  |  | 29c. LICENSE NUMBER<br><b>D36552</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/8/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>6121 MONTROSE ROAD. ROCKVILLE MD. 20852</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 13 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2011 02

2011 02 01

2011 02 02

2011 02 03

2011 02 04

2011 02 05

2011 02 06

90 26685

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Morton Kudysh</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>8</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>0145 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>125-12-5753A</b>   |  | 5. SEX<br><b>M</b> <input type="checkbox"/> F <input type="checkbox"/> |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>8-9-20</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Brooklyn, N.Y.</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Suburban Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bethesda</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Bethesda</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>5225 Pooks Hill Road, #1204 North</b>   |  |
| 10f. ZIP CODE<br><b>20814</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>World War II</b>  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>5+</b>   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Attorney</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Law</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frank Kudysh</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rose Saltzman</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Arnell Kudysh (Wife)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number, Rural Route Number, City or Town, State, Zip Code)<br><b>#1204N. 5225 Pooks Hill Road; Bethesda, Maryland 20814</b>                                    |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>King David Memorial Garden</b>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>Falls Church, V.A.</b>   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Frank A. Stone</b>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Danzansky-Goldberg Memorial Chapels</b>   |  |  |  | 1170 Rockville Pike Rockville, M.D. 20852   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |   |  |  |  |
| a. <b>CARDIOPULMONARY ARREST</b>   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| b. <b>MYOCARDIAL INFARCTION</b>  |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| c. <b>CORONARY ARTERY DISEASE</b>  |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| d.   |  |  |  |   |  |  |  |
| Approximate Interval Between Onset and Death<br><b>2 weeks</b>   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  |  |  |   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  |   |  |  |  |
| 28b. TIME OF INJURY<br><b>M</b>  |  |  |  |   |  |  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Barry S. Talesnick MD</b>  |  |  |  |   |  |  |  |
| 29c. LICENSE NUMBER<br><b>Maryland D26449</b>  |  |  |  |   |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>9/8/90</b>   |  |  |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Barry S. Talesnick MD 5530 Wisconsin Ave Chevy Chase Maryland 20815</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 13 '90</b>   |  |  |  |   |  |  |  |
| 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |  |  |   |  |  |  |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician to the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





90 26686

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>THOMAS HUDNER KING, JR.</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09-14-90</b>   |  | 3. TIME OF DEATH<br><b>11:25 P</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>332-38-9583</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>43</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10-15-46</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>N.I.H., THE CLINICAL CENTER</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BETHESDA, MARYLAND</b>  |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>None</b>   |  | 10b. COUNTY<br><b>None</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>WASHINGTON, DC</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>1625 19th Street, N.W.</b>   |  |  |  | 10f. ZIP CODE<br><b>20009</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                          |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>5+</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Foreign Service Officer U.S. Government</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Agency for International Development</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas Hudner King, Sr.</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lois Brown</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Terrance Scott Williams</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1625 19th Street N.W. Washington D.C. 20009</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc.</b>  |  | 20c. LOCATION — City or Town, State<br><b>Bethesda, Maryland</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Will E. Bann, Jr.</i> M00672  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  | a. <b>WIDE SPREAD METASTATIC MALIGNANT MELANOMA 4 YRS</b>  |  |   |  |   |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|   |  | c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|   |  | d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Rendell Concepcion</i> M.D.   |  |  |  | 29c. LICENSE NUMBER<br><b>A-39752</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>09/15/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Rendell Concepcion</i> M.D. 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 17 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26687

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |   |  |   |  |   |  |  |  |
|---|--|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ODELL LIVERLY LIVERLY</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>9</b> YEAR <b>90</b>   |  |   |  | 3. TIME OF DEATH<br><b>2:15 AM</b>  |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>405-20-1062</b>   |  |   |  | 5. SEX<br><b>XX</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.  |  | 7. DATE OF BIRTH<br>MONTH <b>JAN</b> DAY <b>9</b> YEAR <b>27</b>                                |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>KENTUCKY</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ANNR ARUNDEL MEDICAL CENTER</b>  |  |   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ANNAPOLIS, MARYLAND</b>   |  |   | 9c. COUNTY OF DEATH<br><b>ANNE ARUNDEL</b> |   |  |  |  |
| RESIDENCE OF DECEDENT   |  |   |  |  |  |   |  |   |  |   |  |  |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>ANNE ARUNDEL</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>ANNAPOLIS, MARYLAND</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>3523 NEWPORT AVENUE</b>  |  |   |  | 10f. ZIP CODE<br><b>21403</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>W.W.11</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLK</b>                        |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>?</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>RETIRED U.S. NAVY</b>  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>*****</b>  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WILLIE LIVERLY</b>  |  |   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>BETTY ESTERS</b>  |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>PAMELA C. CROWNER</b>  |  |   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1358 MOYER COURT * ANNAPOLIS, MD. 21403</b> |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MD. VET. CEMETERY</b>   |  |   |  | 20c. LOCATION — City or Town, State<br><b>CROWNSVILLE, MD</b>                                   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>CHARLES E. HICKS 111</b>  |  |   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HICKS FUNERAL HOME 1922 FOREST DR. ANNA. MD. 21401</b>   |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Failure</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>ARDS</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature] mb</b>  |  |   |  |  |  | 29c. LICENSE NUMBER<br><b>036761</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/9/90</b>  |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>M ROSSMAN 2568 A RIDGE RD ANNAPOLIS</b>   |  |   |  |  |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 12 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  |   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

22-2-2

22-2-2

22-2-2

...

22-2-2

22-2-2

22-2-2

...

22-2-2

22-2-2

22-2-2

...

22-2-2

22-2-2

22-2-2

22-2-2

90 26688

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARJORIE L. LYMAN</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 11 1990</b>  |  | 3. TIME OF DEATH<br><b>A</b> M  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>433-70-7293</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>85 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12-30-1904</b>  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Ginger Cove Care Center</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Annapolis</b>   |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>  |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Annapolis</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>205 Rivercrescent Drive</b>   |  |  |  | 10f. ZIP CODE<br><b>21401</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas Chambers Young</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Roberts Furness</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Marjorie Miller</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12 Grant Lane Wayne, Pa 19087</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>                                      |  | 20c. LOCATION — City or Town, State<br><b>Alexandria, Va.</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Donald S. Lyf</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Taylor Funeral Chapel Annapolis, Md.</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebral hemorrhage</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Age, coronary artery, atherosclerosis</b>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 26a. DATE OF INJURY (Month, Day, Year)   |  | 26b. TIME OF INJURY<br><b>M</b>   |  | 26c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
|  |  | 26d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 26e. DESCRIBE HOW INJURY OCCURRED   |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Wm. L. Lyf</i>   |  | 29c. LICENSE NUMBER<br><b>D24768</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-13-90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>600 RIDGELY AVE, ANNAPOLIS</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>9/15/90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26689

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Margaret Lutostanski</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>9</i> DAY <i>18</i> YEAR <i>90</i>   |  | 3. TIME OF DEATH<br><i>3:30 PM</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>415-30-4881</i>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>70</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>1-29-20</i>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Pennsylvania</i>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Denton Hospital &amp; Medical Center</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore</i>  |  |
| 9c. COUNTY OF DEATH<br><i>City</i>   |  |  |  | 10a. STATE<br><i>Maryland</i>   |  | 10b. COUNTY<br><i>Carroll County</i>   |  |
| 10c. CITY, TOWN OR LOCATION<br><i>Sykesville</i>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><i>6111 Oakland Mills Road</i>   |  |
| 10f. ZIP CODE<br><i>21784</i>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Volunteer</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Hospital</i>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Michael Fekete</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Suzanne ?</i>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Mr. Milton Lutostanski</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>6111 Oakland Mills Road Sykesville, MD 21784</i>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Lake View Cemetery</i>   |  | 20c. LOCATION — City or Town, State<br><i>Sykesville, MD</i>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Brian L. Haight</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>HAIGHT FUNERAL HOME (P.O. Box 195)<br/>Sykesville, MD 21784 (301) 795-1400</i>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Lung Cancer</i>   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>old cerebrovascular accident</i>  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>H. L. Murce, Jr. MD DHA</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>D14622</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9/18/90</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>H. L. Murce, Jr. MD 6115 Charles St, Balto MD 21223</i>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>SEP 20 '90</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26690

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARGARET LYNCH</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>SEPTEMBER</b> DAY <b>6</b> YEAR <b>1990</b>  |  |  |  | 3. TIME OF DEATH<br><b>1233</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>088-22-0640</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>08/25/1904</b>                          |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>NEW YORK</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Peninsula General Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Salisbury</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>Wicomico</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>WICOMICO</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>SALISBURY</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>1515 RIVERSIDE DRIVE, APT. B-107</b>  |  |  |  | 10f. ZIP CODE<br><b>21801</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE/CAUC.</b>     |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th grade</b> College (1-4 or 5+) <b>CANDY</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>MANAGER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>CANDY</b>                                       |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>CHRISTIAN SCHOENWANDT</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CHARLOTTE (MAIDEN NAME UNKN)</b>  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>(SON) RAYMOND J. CURRAN, SR.</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>308 HIGH ST., CAMBRIDGE, MD. 21613</b>  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>SALISBURY CREMATORY</b>   |  |   |  | 20c. LOCATION — City or Town, State<br><b>SALISBURY, MD.</b>                         |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Raymond J. Curran</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>CURRAN FUNERAL HOME<br/>308 HIGH ST., CAMBRIDGE, MD. 21613</b>   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute M.I.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF): <b>CAO</b><br>b. DUE TO (OR AS A CONSEQUENCE OF): <b>Atherosclerosis</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>→ atrial fibrillation</b><br><b>CHF.</b>  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <b>1</b> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Blair J. Curran M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D 17181</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/7/90</b>                                 |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Bal Agarwal 614C Eastern Shore Drive Salisbury, Md.</b>  |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 14 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WILLIAM ALLEN LARGENT</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>6</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>2:35PM</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>348-22-0741</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>61</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 8, 1929</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Illinois</b>  |  |  |  | 9a. CITY, TOWN OR LOCATION OF DEATH<br><b>Easton</b>  |  | 9b. COUNTY OF DEATH<br><b>Talbot County</b>   |  |
| 9c. FACILITY NAME (If not institution, give street and number)<br><b>Memorial Hospital at Easton</b>   |  |  |  |   |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Talbot</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>St. Michaels.</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>28 Martingham Drive</b>   |  |  |  | 10f. ZIP CODE<br><b>21663</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Marines WWII Korea</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>4</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Sr. Vice Pres. Sales &amp; Marketing Keyes Fibre</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Largent</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Fern Myers</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Marilyn S. Largent</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>28 Martingham Dr. P.O. Box 768 St. Michaels, Md. 21663</b>                                      |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Lee Crematory</b>   |  | 20c. LOCATION — City or Town, State<br><b>Clinton, Maryland</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Harrison E. Leonard</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Harrison E. Leonard Funeral Home 21663<br/>312 S. Talbot St. St. Michaels, Maryland</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerotic cardiovascular disease</b>   |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED  |  |   |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Mario F. Golle, Jr.</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-7-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARIO F. GOLLE, JR., MD 111 Penn Street, Baltimore, MD 21201 vc</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 10 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26692

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ABRAMO LUZZATTO</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>SEPT</b> DAY <b>12</b> YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>8:20 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>081-12-9006</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JULY 7, 1901</b>                           |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MONTGOMERY GENERAL HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>OLNEY</b>  |  | 9c. COUNTY OF DEATH<br><b>MONTGOMERY</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |  |  |
| 10a. STATE<br><b>FLORIDA</b>   |  | 10b. COUNTY<br><b>MARTIN</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>STUART</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>2600 EAST OCEAN BOULEVARD, BLDG. C, #6</b>  |  |  |  | 10f. ZIP CODE<br><b>34996</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>              |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>4</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>ART PUBLISHER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>PUBLISHING</b>                                  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>UNKNOWN</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>UNKNOWN</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>RUDOLPH G. LUZZATTO (SON)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14514 CARROLTON ROAD, ROCKVILLE, MARYLAND 20853</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>METROPOLITAN CREMATORY</b>  |  | 20c. LOCATION — City or Town, State<br><b>ALEXANDRIA, VIRGINIA</b>                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Francis J. Collins</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W., SIL.SP., MD 20901</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary arrest</b>  |  |  |  |  |  |  |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF): <b>RL pneumonia</b>  |  |  |  |  |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF): <b>COPD</b>  |  |  |  |  |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ep prostate stage IV<br/>H of adenocarcinoma colon<br/>depression, coughing</b>   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>W. J. Stendup</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>31957</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/12/90</b>                                |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MILAN JASEK, 1101 Spout International Drive, Silver Spring, MD 20906</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 17 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 1314

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely worded in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26693

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MOORE (AND), ELMIRA</b> ELMIRA MORELAND  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 12 90</b>   |  | 3. TIME OF DEATH<br><b>1030</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-32-3190</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12/11/01</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ANNE ARUNDEL MEDICAL CENTER</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>ANNAPOLIS</b>   |  | 9c. COUNTY OF DEATH<br><b>A.A.</b>  |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>ANNE ARUNDEL</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>ANNAPOLIS</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>701 GLENWOOD ST. APT. 521</b>  |  |   |  | 10f. ZIP CODE<br><b>21401</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JAMES PARKER</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>GEORGIANNA SELLMAN</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>BESSIE WATKINS</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3955 YELLOW BANK RD. DUNKIRK, MD. 20754</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT. ZION CHURCH CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>LOTHIAN, MARYLAND</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Larry H. Reese</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>821 WEST ST. ANNAPOLIS, MD. 21401</b><br><b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>myocardial infarction</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <b>HASCD</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |   |  |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Donna C. Roome, M.D.</i>  |  |   |  | 29c. LICENSE NUMBER<br><b>810698</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/12/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DONALD C. ROOME, M.D. 1616 FOREST DRIVE ANNAPOLIS 21405</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 14 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Rodell</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1942-1943 - 1944 - 1945



90 26694

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BENJAMIN HERSHEL Marmer</b>  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>05</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>1455</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-20-0695</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>DEC. 3, 1926</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  |   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>Peninsula General Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Salisbury</b>   |  | 9c. COUNTY OF DEATH<br><b>Wicomico</b>  |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>WICOMICO</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>SALISBURY</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>410 LOBLOLLY LANE</b>  |  | 10f. ZIP CODE<br><b>21801</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>  |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (8-12) <b>12 YEARS</b><br>College (1-4 or 5+) <b>4 YEARS</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>CREDIT MANAGER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>FOOD DISTRIBUTERS</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>MILTON (unk) MARMER</b>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>RHEA (unk) SCHAPIRO</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CYVIA F. MARMER-WIFE</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>410 LOBLOLLY LANE, SALISBURY, MD 21801</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION <b>9/7/90</b><br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BETH ISRAEL CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>SALISBURY, MD</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>J. Holloway</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HOLLOWAY FUNERAL HOME, PA</b><br><b>501 SNOW HILL RD, SALISBURY, MD 21801</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hepatorenal Syndrome.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">{</div> <div> <b>hepatic encephalopathy</b><br/> <b>Cirrhosis of liver with portal hypertension</b> </div> </div> |  |   |  |   | Approximate interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Arteriosclerotic heart disease with history of cardiac arrhythmias</b>   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
|   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |
| 29a. SIGNATURE AND TITLE OF CERTIFIER<br><i>Kota L. Chandra</i>   |  | 29b. LICENSE NUMBER<br><b>D 25691</b>   |  | 29c. DATE SIGNED (Month, Day, Year)<br><b>9/5/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Kota L. Chandra 306 Kay Ave Salisbury, MD 21801</b>   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 6 2 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26695

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>EARL Wm MACDONALD</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>18</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>1:15P</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218 01 95.33</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 18, 1908</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Golden Age Guest Home</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Sykesville</b>  |  | 9c. COUNTY OF DEATH<br><b>Carroll</b>  |  |
| RESIDENCE OF DECEASED  |  |  |  |   |  |  |  |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>Carroll</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Sykesville</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>514 Piney Run Court</b>   |  |  |  | 10f. ZIP CODE<br><b>21784</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br><b>White</b>   |  |
| 15. DECEASED'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>4th Grade</b>  |  | 16a. DECEASED'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Inspector</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Automobile Gen. Motors</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Hamilton MacDonald</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ellen Scully</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Patricia M. Serio</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>514 Piney Run Court Sykesville, Md. 21784</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Druid Ridge Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Pikesville, Md.</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Harry W. Haight</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>21784 Haight Funeral Home Box 195 Sykesville, Md.</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Lung Cancer</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>PATRICK TURNER MD / Patrick Turner MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D20806</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/18/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>1425 Liberty Rd Sykesville Md 21784</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 20 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26696

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |  |   |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Helen Benedict McElroy</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>Sept</i> DAY <i>17</i> YEAR <i>1990</i>   |  |   |  | 3. TIME OF DEATH<br><i>3:10 p.m.</i>   |   |  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>234 60 6389</i>  |  |  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>75</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>6/10/ 1915</i>                          |   | 8. BIRTHPLACE (State or Foreign Country)<br><i>QUIRIGUA, GUATEMALA</i> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>WASHINGTON CO. HOSPITAL</i>   |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>HAGERSTOWN</i>  |  |  |   | 9c. COUNTY OF DEATH<br><i>WASHINGTON</i>                               |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |   |  |  |   |  |  |
| 10a. STATE<br><i>MARYLAND</i>  |  |  | 10b. COUNTY<br><i>WASHINGTON</i>   |  |  | 10c. CITY, TOWN OR LOCATION<br><i>SMITHSBURG</i>  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |
| 10e. STREET AND NUMBER<br><i>240 RAINBOW AVE. HAVENWOOD HILL</i>   |  |  |  |  |  | 10f. ZIP CODE<br><i>21783</i>   |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>WHITE</i>                             |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>4+</i>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>HOMEMAKER</i>  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>DOMESTIC</i>                                    |   |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>SYDNEY MERRITT BELLINGER</i>   |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>HILDA nm Southern</i>   |  |  |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>WILBUR R. McELROY, Ph.D.</i>  |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>240 RAINBOW AVE. SMITHSBURG, MARYLAND 21783</i>   |  |  |   |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>SMITHSBURG CREMATORY</i>  |  |   |  | 20c. LOCATION — City or Town, State<br><i>SMITHSBURG, MD</i>                         |   |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael P. Long</i> PA013157L  |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>R.G. SELLERS FUNERAL HOME 17201<br/>297 Philadelphia Ave. Chambersburg, PA</i>   |  |  |   |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |   |  |  |   |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hepatocellular Carcinoma, primary</i>   |  |  |  |  |  |   |  |  |   |  |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |  |  |   |  |  |   |  |  |
| a. <i>Due to (OR AS A CONSEQUENCE OF):</i><br><i>Liver's Cirrhosis</i>   |  |  |  |  |  |   |  |  |   |  |  |
| b. <i>Due to (OR AS A CONSEQUENCE OF):</i>   |  |  |  |  |  |   |  |  |   |  |  |
| c. <i>Due to (OR AS A CONSEQUENCE OF):</i>   |  |  |  |  |  |   |  |  |   |  |  |
| d. <i>Due to (OR AS A CONSEQUENCE OF):</i>   |  |  |  |  |  |   |  |  |   |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Chronic Obstructive Pulmonary disease</i>   |  |  |  |  |  |   |  |  |   |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |  |   |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED                                      |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |   |  |  |   |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robert Brul personal physician</i>   |  |  |  |  |  | 29c. LICENSE NUMBER<br><i>D04359</i>  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>Sept 20, 1990</i>   |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type Print)<br><i>Robert Brul 1459 Potomac Ave. Hagerstown</i>  |  |  |  |  |  |   |  |  |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>SEP 24 '90</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>  |  |   |  |  |   |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26697

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>CARROLL LESLIE MORGAN  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 12, 1990  |  | 3. TIME OF DEATH<br>12:45 AM M  |   |
| 4. SOCIAL SECURITY NUMBER<br>215-30-5367   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>92 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Mar. 6, 1898  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  | 9a. FACILITY NAME (If not Institution, give street and number)<br>Bel Forest Nursing Home  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Forest Hill  |  | 9c. COUNTY OF DEATH<br>Harford  |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Harford   |  | 10c. CITY, TOWN OR LOCATION<br>Bel Air  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>502 Ponderosa  |  |  |  | 10f. ZIP CODE<br>21014  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) _____  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Farmer                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Agriculture   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Thomas Morgan  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Roberta Anderson  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Irene A. Morgan  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>502 Ponderosa Road, Bel Air, Md. 21014   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Bel Air Memorial Gardens   |  | 20c. LOCATION — City or Town, State<br>Bel Air, Md.   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Howard K. McComas III</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Howard K. McComas III Funeral Home, P.A.<br>1317 Cokesbury Road, Abingdon, Md.  |  |   |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>respiratory arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>pneumonia</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>dementia</i>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 27a. DATE OF INJURY (Month, Day, Year)   |  | 27b. TIME OF INJURY<br>M  |  | 27c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
| 27d. DESCRIBE HOW INJURY OCCURRED  |  | 27e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 27f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>David S. Dunn</i>  |  |  |  | 29c. LICENSE NUMBER<br>D32299   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/12/90  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DAVID S. DUNN 2105 LAUREL BUSH RD   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 12 90   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. The law also requires that the death certificate be signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

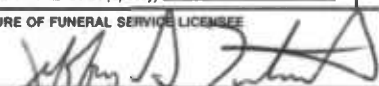






90 26698

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mary F. Morin</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 13, 1990</b>   |  |  |  | 3. TIME OF DEATH<br><b>5:00am</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577 52 0833</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Oct. 9, 1907</b>                           |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>New York</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>15400 Bassett Lane #1C</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Silver Spring</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>15400 Bassett Lane #1C</b>  |  |  |  | 10f. ZIP CODE<br><b>20906</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>           |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>-</b><br>College (1-4 or 5+) <b>4</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Teacher</b>                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Public Schools</b>   |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Thomas J. Fitzgerald</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elizabeth Tilson</b>  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Howard Morin</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9902 LaDuke Drive, Kensington, Maryland 20895</b>   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Olivet Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Washington, D.C.</b>  |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br> <b>M00689</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Md. 20814</b>  |  |  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrest</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><div style="display: flex; align-items: center;"> <div style="font-size: 4em; margin-right: 10px;">}</div> <div> <p><b>Coronary Arteriosclerosis</b></p> <p><b>Due to (or as a consequence of):</b></p> <p><b>Due to (or as a consequence of):</b></p> <p><b>Due to (or as a consequence of):</b></p> </div> </div> |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>_____  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>D08546</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>September 13, 1990</b>                     |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John F. Tauber, M.D. 8218 Wisconsin Avenue, #414, Bethesda, Md. 20814</b>  |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 17 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use of the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26699

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |   |
|--|--|--|--|---|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ruth Miller</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 - 12 90</b>  |  | 3. TIME OF DEATH<br><b>12:14 PM</b>  |   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>332-32-3600</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>64</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>February 19, 1926</b>  |   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Mississippi</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Holy Cross Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>  |   |   |
| 9c. COUNTY OF DEATH<br><b>Montgomery County</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery County</b>  |   |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Wheaton</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>1911 LaPointe Drive</b>   |   |   |
| 10f. ZIP CODE<br><b>20902</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>   |   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)   |  |  |  | 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Seamstress</b>   |  | 18b. KIND OF BUSINESS/INDUSTRY<br><b>Self Employed Independent</b>   |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Eugene Baxstrom</b>  |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Not Available</b>   |  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Freddie Miller</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1911 LaPointe Drive, Wheaton, MD 20902</b>  |  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Jefferson Barracks National Cen. St Louis, Missouri</b>  |  | 20c. LOCATION — City or Town, State  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>M00690</b><br><b>Howard D. Carson</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>C. W. Edwards Funeral Home</b><br><b>P.O.B. 395, Bowling Green, Virginia 22427</b>   |  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>acute myocardial infarction</b>   |  |  |  |   |  |  |   |   |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |   |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 29a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |   |
| 29b. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |   |   |
| 29c. SIGNATURE AND TITLE OF CERTIFIER<br><b>John Tauler</b>  |  |  |  | 29d. LICENSE NUMBER<br><b>D08546</b>  |  | 29e. DATE SIGNED (Month, Day, Year)<br><b>9-12-90</b>  |   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John Tauler 8218 Wisconsin Ave.</b>  |  |  |  |   |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 14 90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the funeral transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26700

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JAMES MCKEE</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>8-29-90</b>  |  | 3. TIME OF DEATH<br><b>12:30 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>19-28-9170</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>56</b> YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>9-17-33</b>  |  | 8. BIRTHPLACE (State or Foreign)<br><b>Baltimore</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>CHURCH HOSPITAL CORPORATION</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>BALTO.</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>1508 GALENA ROAD</b>   |  |   |  | 10f. ZIP CODE<br><b>21221</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>KOREAN</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>SUPPER. FOR HWK.</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>CITY OF BALTO.</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JAMES L. MCKEE</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LILLIAN CICHON</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ALBERTA D. MCKEE</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1508 GALENA RD. BALTO. MD. 21221</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>OKLAHAW CEM.</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTO. CO. MD.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Thomas J. Skarda</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SKARDA F.H. 2829 HUDSON ST</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |  |   | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>metastatic cancer of esophagus</b>   |  |   |  |   |  |   |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Beena Nagpal</b>  |  | 29c. LICENSE NUMBER<br><b>N/A</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/29/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR BEENA NAGPAL M.D. 100 N. BROADWAY BALTIMORE MD 21231</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 31 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Josh Davidson-Randall</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26701

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>thurston Nickolas Nick</i>  |  |   |  | 2. DATE OF DEATH<br>MONTH <i>9</i> DAY <i>18</i> YEAR <i>90</i>   |  | 3. TIME OF DEATH<br><i>1:00 P M</i>   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>214-16-0154</i>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>70</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>April 3, 1920 Mt. Briar, Md.</i>                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Washington County Hospital</i>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Hagerstown</i>  |  | 9c. COUNTY OF DEATH<br><i>Washington</i>  |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |  |
| 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Washington</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Keedysville</i>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>4657 Mt. Briar Rd.</i>  |  |   |  | 10f. ZIP CODE<br><i>21756</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>W. W. Two</i>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><i>8</i>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Maintenance Labor</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>National Park System</i>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Joseph Franklin Nick</i>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Maude Geneva Mullendore</i>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Martha G. Nick</i>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>4657 Mt. Briar Rd. Keedysville, Md. 21756</i>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Mt. Zion Cemetery</i>  |  | 20c. LOCATION — City or Town, State<br><i>Locust Grove, Md.</i>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John H. Bast, Jr.</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>BAST FUNERAL HOME, 7606 Boonsboro Pike Boonsboro, Md. 21713</i>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Septic Shock</i>  |  |   |  |   |  |   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  |   |  |   |  |   |  |
| a. DUE TO (OR AS A CONSEQUENCE OF): <i>Pneumonia</i><br>b. DUE TO (OR AS A CONSEQUENCE OF): <i>Squamous cell carcinoma of lung with extension 8 months</i><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.  |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Acute anterior wall myocardial infarction</i>   |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>R. L. Regler MD</i>  |  |   |  | 29c. LICENSE NUMBER<br><i>D 26577</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9/18/90</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>R. L. Regler MD Keedysville, Md 21756</i>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>SEP 21 '90</i>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John H. Bast, Jr.</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

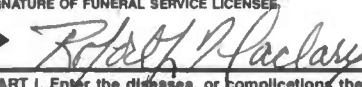
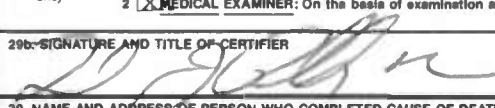

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>TRUONG HOANG Nguyen</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9-12-90</b>   |  | 3. TIME OF DEATH<br><b>11:38PM</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>586-50-4190</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>21</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>JUNE 27, 1969</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>VIET NAM</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>3506 56th Place</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cheverly</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Prince Georges Co.</b>   |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>PRINCE GEORGES</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>CHEVERLY</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>3506 56th PLACE</b>   |  |
| 10f. ZIP CODE<br><b>20784</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>VIETNAM</b>  |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>VIETNAMESE</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>1</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>ENGINEER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>HOTEL</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>LANH NGUYEN</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HOA VU</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>HOA VU (MOTHER)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3506 56th PLACE, CHEVERLY, MARYLAND 20784</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>METROPOLITAN CREMATORY</b>  |  | 20c. LOCATION — City or Town, State<br><b>ALEXANDRIA, VIRGINIA</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W., SIL.SP., MD 20901</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Gunshot wound of head</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>XX <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>9-12-90</b>   |  | 28b. TIME OF INJURY<br><b>11:30PM</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Subject shot</b>   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>Home</b>  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>3506 56th Place, Cheverly, Prince Georges County, Maryland</b>  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  | 29c. LICENSE NUMBER<br><b>OCME</b>   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>9-13-90</b>  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>FRANK PERETTI, MD 111 Penn Street, Baltimore, MD 21201</b>   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 17 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



REG. NO.

DHMH-16 Rev 1/85



90 26704

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |  |
|--|--|--|--|---|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EDNA E. OG-BURN</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPTEMBER 9, 1990</b>  |  | 3. TIME OF DEATH<br><b>0030</b>   |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>224-28-8364</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>65</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>6/2/25</b>  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Peninsula General Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Salisbury</b>   |  | 9c. COUNTY OF DEATH<br><b>Wicomico</b>  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |  |
| 10a. STATE<br><b>VA</b>  |  | 10b. COUNTY<br><b>Accomack</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Bloxom, VA. RFD</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br><b>NA</b>  |  |  |  | 10f. ZIP CODE<br><b>23308</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>IN</b> College (14 or 5+)   |  | 18a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>U.S.D.A INSPECTOR</b>  |  | 18b. KIND OF BUSINESS/INDUSTRY<br><b>POULTRY</b>  |  |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HAROLD ANNIS</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ELIZABETH MEARS</b>   |  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JAMES OGBURN</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>BLOXOM, VA R.F.D.</b>   |  |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>PARKSLEY CEM</b>  |  | 20c. LOCATION — City or Town, State<br><b>PARKSLEY VA.</b>  |  |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Carl G. Thon</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>THORNTON FUNERAL HOME<br/>PARKSLEY, VA 23421</b>   |  |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   | Approximate interval Between Onset and Death<br><b>6 mos</b>  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Lung Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |   |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>David E. Conall MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>026278</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-9-90</b>  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>David E. Conall MD 145 E. Carroll St. Salisbury, MD 21801</b>  |  |  |  |   |  |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 18 90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |   |  |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26705

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |                                |   |   |
|---|--|--|--|---|--------------------------------|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Willis F. Purdy</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>9-11-90</i>  |                                | 3. TIME OF DEATH<br><i>0038 M</i>   |   |
| 4. SOCIAL SECURITY NUMBER<br><i>216-24-8157</i>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><i>64</i> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year)<br><i>3/30/26</i>   |   |
| 8a. FACILITY NAME (If not institution, give street and number)<br><i>90 Beach Drive</i>   |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><i>Edgewater</i>   |                                | 8c. COUNTY OF DEATH<br><i>AA</i>  |   |
| 10a. STATE<br><i>md</i>   |  | 10b. COUNTY<br><i>AA</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Edgewater</i>   |                                | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><i>90 Beach Drive</i>   |  |  |  | 10f. ZIP CODE<br><i>21037</i>   |                                | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>1950-56</i>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>                      |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><i>11</i>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>Carpentry</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Construction</i>   |                                |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>John Thomas Purdy</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Elizabeth Evelyn Bullen</i>   |                                |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Mary Taylor Purdy</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>90 Beach Drive, Edgewater, MD 21037</i>   |                                |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Hillcrest Cemetery</i>  |  | 20c. LOCATION — City or Town, State<br><i>Annapolis, MD</i>   |                                |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Thomas A. Hardisty</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Hardesty Funeral Home P.A.<br/>12 Ridgely Ave. Annapolis, MD 21401</i>   |                                |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>C.O.P.D.</i><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |                                |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |                                |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |                                |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |                                |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |                                | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |                                |   |   |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>William R. Jones, MD Deputy</i>  |  | 29c. LICENSE NUMBER<br><i>D06054</i>  |                                | 29d. DATE SIGNED (Month, Day, Year)<br><i>9/11/90</i>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>William R. Jones, MD 695 America 21035</i>  |  |  |  |   |                                |   |   |
| 31. DATE FILED (Month, Day, Year)<br><i>SEPT 12 1990</i>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |                                |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 would be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

104 77 02

104 77 02

104 77 02

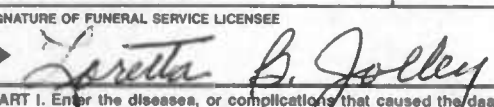

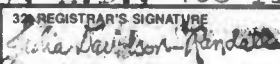
104 77 02



90 26706

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Naomi Parker</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>11</b> YEAR <b>90</b>   |  |  |  | 3. TIME OF DEATH<br><b>0150</b> M   |  |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-22-7506</b>  |  |  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS. |  | IF UNDER 1 YEAR<br>MONTHS <b>05</b> DAYS <b>29</b> HOURS <b>01</b> MIN.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>05-29-01</b> |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>DEAL ISLAND, MD.</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>PENINSULA GENERAL HOSP. CT.</b>   |  |  |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SALISBURY</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>WICOMICO</b>  |  |
| 10a. STATE<br><b>MD.</b>   |  |  |  | 10b. COUNTY<br><b>SOMERSET</b>   |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>DEAL ISLAND</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>BOX 56</b>  |  |  |  |  |  |  |  | 10f. ZIP CODE<br><b>21821</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>B.S</b> College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>SCHOOL TEACHER</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>RETIRED</b>  |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>FRANK PARKER</b>   |  |  |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MAMIE WATERS</b>  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARGARET P. HARRIS</b>  |  |  |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>ADD. SAME AS ABOVE</b>  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other)<br><b>JOHN WESLEY UM.</b>   |  |  |  | 20c. LOCATION — City or Town, State<br><b>DEAL ISLAND, MD.</b>  |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>RTE. 2, BOX 920, SALISBURY, MD. 21801</b>  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Arteriosclerotic Cardiovascular Disease</b>  |  |  |  |  |  |  |  |   |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |   |  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |  |  |  |  |   |  |  |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |   |  |  |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |   |  |  |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |   |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M                         |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED                      |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> <b>Deputy M.E.</b>  |  |  |  |  |  |  |  | 29c. LICENSE NUMBER<br><b>D03599</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>09-11-90</b> |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John T. Bulkeley, M.D., 108 Pine Bluff Rd., Salisbury, Md. 21801</b>   |  |  |  |  |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 18 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26707

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Robert L. Peterson</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>07</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>2240</b> M   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>216-40-4034</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>51</b> YRS. | IF UNDER 1 YEAR<br>MONTHS <b>09</b> DAYS <b>07</b>  | IF UNDER 24 HRS.<br>HOURS <b>00</b> MIN. <b>00</b> | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12-02-38</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>U.S. Rte. 50</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Salisbury</b>   |   |
| 9c. COUNTY OF DEATH<br><b>Wicomico</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Wicomico</b>  |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Salisbury</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>900 West Road</b>  |   |
| 10f. ZIP CODE<br><b>21801</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Janitor</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Office Buildings</b>   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charley Quailes, Jr.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Grace Peterson</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lutisha J. Gibbs</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Rt. 2, Box 206A, Georgetown, DE 19947</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Federal Hill Cem.</b>  |  | 20c. LOCATION — City or Town, State<br><b>Federalburg, MD</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Michael J. Etkow</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Frampton-Hawkins Funeral Home<br/>Federalburg, MD PO Bx 43 21632</b>   |  |   |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Multiple Trauma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Street</b>   |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>09-07-90</b>  |  | 28b. TIME OF INJURY<br><b>2200</b> M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |   |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>U.S. Rte. 50 - West</b>  |  | 28e. DESCRIBE HOW INJURY OCCURRED<br><b>Passenger in auto accident</b>   |  |   |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>Salisbury, Maryland</b>  |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John T. Bulkeley Deputy M.E.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D03599</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>09-08-90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John T. Bulkeley, M.D., 108 Pine Bluff Rd., Salisbury, Md. 21801</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 12 90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John T. Bulkeley</b>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0013: 00

OHMH-16 Rev 1/86



90 26709

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |   |  |
|---|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CLYDE OSWALD PRITCHETT</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>12</b> DAY <b>12</b> YEAR <b>1990</b>  |  |  |  | 3. TIME OF DEATH<br><b>0940</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-16-8103</b>   |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>06/21/1902</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Peninsula General Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Salisbury</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>Wicomico</b>  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>DORCHESTER</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>BISHOPS HEAD</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>1934 EAST TEDIOUS CREEK ROAD</b>   |  |  |  | 10f. ZIP CODE<br><b>21611</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |
| 11. MARITAL STATUS<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES <b>XX</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE/CAUC.</b>                                     |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>5th grade</b> College (1-4 or 5+) <b>College</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>WATERMAN</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>SHELLFISH</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>FRANKLIN PRITCHETT</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HATTIE SLACUM</b>   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print) (SPOUSE)<br><b>DOROTHEA A. PRITCHETT</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1934 EAST TEDIOUS CREEK RD., BISHOPS HEAD, MARYLAND 21611</b>   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>DORCHESTER MEMORIAL PARK</b>   |  | 20c. LOCATION — City or Town, State<br><b>CAMBRIDGE, MARYLAND</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John Bureau Prommel</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>CURRAN FUNERAL HOME 21613<br/>308 HIGH STREET, CAMBRIDGE, MD.</b>  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardio pulmonary failure</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>arterio sclerotic heart disease</b><br><br>c. <b>Hypertension</b><br><b>Sigmoid Volvulus with ileus</b><br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>8</b> <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO                   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Kota Chandra</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 25091</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/12/90</b>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Kota Chandra 306 Kay Ave. Salisbury, Md. 21801</b>  |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 14 '90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Pondella</i>   |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26710

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |   |  |  |  |  |  |                                   |  |
|---|--|---|--|--|--|---|--|--|--|--|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><del>XXXXXXXXXX</del> MABEL ELIZABETH PRICE   |  |   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9 13 90   |  | 3. TIME OF DEATH<br>3:45 P M   |  |  |  |                                   |  |
| 4. SOCIAL SECURITY NUMBER<br>213-16-7122  |  | 5. SEX<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>76 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>07 05 1914  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |  |  |                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>UNION MEMORIAL HOSPITAL   |  |   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE MD.  |  | 9c. COUNTY OF DEATH  |  |  |  |                                   |  |
| 10a. STATE<br>MD.   |  | 10b. COUNTY<br>Worcester  |  | 10c. CITY, TOWN OR LOCATION<br>Ocean City  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |  |  |                                   |  |
| 10e. STREET AND NUMBER<br>5101 Coastal Highway  |  |   |  | 10f. ZIP CODE<br>21842   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |  |  |                                   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white                                |  |  |  |  |  |                                   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11<br>College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>nurses aide  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>general hospital   |  |   |  |  |  |  |  |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>George Pritchett   |  |   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Annie Hart                                 |  |  |  |  |  |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. Otho F. Price   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5101 Coastal Highway, Ocean City MD.  |  |   |  |  |  |  |  |                                   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Dorchester Memorial Park  |  | 20c. LOCATION — City or Town, State<br>Cambridge Md.   |  |   |  |  |  |  |  |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>► Kenneth R. Thomas Jr.  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Thomas Funeral Home<br>700 Locust St. Cambridge Md. 21613  |  |   |  |  |  |  |  |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CARDIAC ARREST</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>MULTI SYSTEM FAILURE</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u>OVARIAN CANCER</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br>MINUTES<br>WEEKS |  |   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____   |  |   |  |  |  |   |  |  |  |  |  |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO          |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Daniel I. Morgan MD  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br>► 9-13-90  |  |  |  |  |  |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DANIEL MORGAN 619 S. SHARP ST. BALT MD 21230   |  |   |  |  |  |   |  |  |  |  |  |                                   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 17 '90   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rodell  |  |  |  |   |  |  |  |  |  |                                   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26711

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Wilbur A. Poffenberger</u>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><u>9-23-1990</u>   |  | 3. TIME OF DEATH<br><u>7:10 P. M</u>   |   |
| 4. SOCIAL SECURITY NUMBER<br><u>217-16-2097</u>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><u>75</u> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><u>11-13-1914</u>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>Maryland</u>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><u>Washington County Hospital</u>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Hagerstown</u>   |   |
| 9c. COUNTY OF DEATH<br><u>Washington</u>  |  |  |  | 10a. STATE<br><u>Maryland</u>  |  | 10b. COUNTY<br><u>Washington</u>   |   |
| 10c. CITY, TOWN OR LOCATION<br><u>Boonsboro</u>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><u>2 Young Avenue</u>  |   |
| 10f. ZIP CODE<br><u>21713</u>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>White</u>   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>6 Yrs.</u><br>College (1-4 or 5+) <u>Owner/ Operator</u>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><u>Owner/ Operator</u>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Hardware Store</u>  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Arthur R. Poffenberger</u>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Alvera Tritapoe</u>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Iona Zittle Poffenberger</u>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>2 Young Avenue Boonsboro, Maryland 21713</u>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Boonsboro Cemetery</u>  |  | 20c. LOCATION — City or Town, State<br><u>Boonsboro, Maryland</u>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>John H. Bast Jr.</u>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>7606 Boonsboro Pike<br/>Bast Funeral Home Boonsboro, Maryland</u>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>CEREBRAL HEMORRHAGE</u><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. <u>CEREBRA LASCULAR DISEASE</u><br>c. <u>DUE TO (OR AS A CONSEQUENCE OF):</u><br>d. <u>DUE TO (OR AS A CONSEQUENCE OF):</u> |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |   |
| 28a. DATE OF INJURY (Month, Day, Year)  |  |  |  | 28b. TIME OF INJURY<br><u>M</u>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>H. J. DeG...</u>  |  |  |  | 29c. LICENSE NUMBER<br><u>D26523</u>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>9/24/90</u>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>DINO J. DELAPOLLA 703 OAK HILL AVE, HAGERSTOWN MD 21740</u>   |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><u>SEP 25 '90</u>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


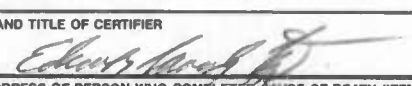

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26712

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |  |
|---|--|--|--|---|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LINDA KAY POFFENBERGER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>20</b> YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>2:10 PM</b> M  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-54-7994</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>43</b> YRS. |   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sep. 6, 1947</b> |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Clearview Nursing Home</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown</b>  |  | 9c. COUNTY OF DEATH<br><b>WASHINGTON</b>  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Washington</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Clear Spring</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |   |  |
| 10e. STREET AND NUMBER<br><b>12367 Harvey Rd.</b>   |  |  |  | 10f. ZIP CODE<br><b>21722</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Maintenance</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Aircraft Manf.</b>   |  |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Richard Ernest Guessford</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bernice Lorraine Poole</b>  |  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John William Poffenberger, Sr.</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12367 Harvey Rd. Clear Spring, MD 21722</b>   |  |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Greenlawn Memorial Park</b>   |  | 20c. LOCATION — City or Town, State<br><b>Williamsport, MD 21795</b>  |  |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>OSBORNE FUNERAL HOMES<br/>P.O. Box # 348 Williamsport, MD 21795</b>  |  |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Carcinoma of Lung</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate interval Between Onset and Death<br><b>2 years</b>  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Auto trauma to Brain, Chest and Abdomen</b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |   |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |   |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |  |
|   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>007857</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/20/90</b>   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>1190 Mt. Aetna Rd HAGERSTOWN, MD 21740 Edson Moody</b>  |  |  |  |   |  |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 21 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*Handwritten signature*

1915

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Estella Presberry   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9 4 90  |  | 3. TIME OF DEATH<br>5:15 A. M  |  |
| 4. SOCIAL SECURITY NUMBER<br>220-03-6651  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>75 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>7-4-15  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>2245 Castleton Road   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Darlington   |  | 9c. COUNTY OF DEATH<br>Harford   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |  |
| 10a. STATE<br>MD.   |  | 10b. COUNTY<br>HARFORD   |  | 10c. CITY, TOWN OR LOCATION<br>DARLINGTON   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO            |  |
| 10e. STREET AND NUMBER<br>2245 Castleton Rd.  |  |  |  | 10f. ZIP CODE<br>21034  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) 7 College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife                       |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Edward Walls   |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Martha Gray  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Irene Rumsey  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2243 Castleton Rd Darlington, MD   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Berkley Cem  |  | 20c. LOCATION — City or Town, State<br>Darlington, MD   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>ARNOLD BEARD FUNERAL SERVICE<br>P.O. Box 188 Haver de Grace, MD   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Smoke and Soot Inhalation<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>(HEAD ONLY) |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>XX YES 2 <input type="checkbox"/> NO      |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br>9-4-90   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>subject recovered from house  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>Home  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>2245 Castleton Rd., Darlington |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  | 29c. LICENSE NUMBER<br>OCME  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |  |   |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-5-90  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>James A. Kaplan, M.D. 111 Penn St., Balto., Md. 21201  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 06 '90   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12 57


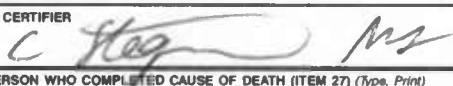
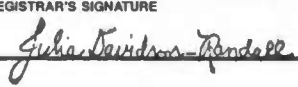
12 57



90 26714

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ma A. Parks</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>Sept.</b> DAY <b>11</b> , YEAR <b>1990</b>   |  |  |  | 3. TIME OF DEATH<br>M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-16-8359</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>3/24/1917</b>   |  |  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>West Virginia</b>  |  |  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Fairmount Star Rt. Box 61C</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Westover,</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>Somerset</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Somerset</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Westover</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>Fairmount Star Rt.</b>  |  |  |  | 10f. ZIP CODE<br><b>21871</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Second (0-12) <b>6</b> College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Luther Hoffman</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Bessie Burgis</b>   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>John Thomas Parks</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Fairmount Star Rt. Box 61C Westover, MD.</b>  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Fairmount Cemetery</b>   |  |  |  | 20c. LOCATION — City or Town, State<br><b>Upper Fairmount, Md.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hinman Funeral Home<br/>127 Somerset Ave., Princess Anne, Md.</b>  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>metastatic breast cancer</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>2 yrs</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  |  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>D25219</b>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>▶  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 13 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

1000 00

90 26715

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Louis Knell Palmer</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 10, 1990</b>   |  | 3. TIME OF DEATH<br><b>6:30 PM</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>217-44-2306</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Mar. 23, 1908</b>                              |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Utah</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Suburban Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bethesda</b>                                      |   |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>  |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Kensington</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>9512 Cable Drive</b>   |   |
| 10f. ZIP CODE<br><b>20895</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (13-16 or 17+) <b>5+</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Attorney</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>General Accounting Office</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Edward J. Palmer</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Clara A. Knell</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Robert L. Palmer</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7907 Indian Head Highway, Oxon Hill, Maryland 20745</b>                                     |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parklawn Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Rockville, Maryland</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Barbara J. McMullen Lawrence</b>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Robert A. Pumphrey Funeral Home/<br/>Bethesda-Chevy Chase, Inc. 7557 Wisconsin<br/>Avenue, Bethesda, Maryland 20814-3501</b>  |  |   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Coronary artery disease</b> |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>days</b><br><b>YEARS</b> |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>anoxic brain injury</b>  |  |  |  |   |  |   |   |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Eric Tannenbaum</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D27886</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/11/90</b>                                       |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ERIC TANNENBAUM 10401 OLD GEORGETOWN RD #204 BETHESDA, MD 20814</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 13 '90</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 1314

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEM:6 per FH  
G-671 1/30/91 cm

90 26716

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |   |  |  |   |  |
|--|--|---|--|---|---|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MARY J. PISANI   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 16 1990   |   | 3. TIME OF DEATH<br>6:30 A.M.  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>578 14 5605   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>80 81 YRS.  |   | 7. DATE OF BIRTH (Month, Day, Year)<br>Jan. 12, 1909                                 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Italy   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>10825 Childs Street  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Silver Spring  |   |  | 9c. COUNTY OF DEATH<br>Montgomery                                |   |  |
| 10a. STATE<br>Maryland   |  |   |  | 10b. COUNTY<br>Montgomery   |   | 10c. CITY, TOWN OR LOCATION<br>Silver Spring   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>10825 Childs St.,  |  |   |  | 10f. ZIP CODE   |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                             |   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 1-8th.<br>College (1-4 or 5+) N/A   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>None  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>None                           |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Giacomo Pisani  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Porzia Rubino  |   |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Frank Pisani   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10825 Childs Street, Silver Spring, Md.  |   |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery   |  |   | 20c. LOCATION — City or Town, State<br>Suitland, Maryland |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Clark E. Wark</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Hines/Rinaldi Funeral Home<br>11800 N.H. Ave., Silver Spring, Md. 20904   |   |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. Cardiac arrest<br>b. Coronary arteriosclerosis<br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Diabetes mellitus. |  |   |  |   |   |  |  | Approximate Interval Between Onset and Death  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |   |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John Tauber</i>  |  |   |  | 29c. LICENSE NUMBER<br>P08546   |   | 29d. DATE SIGNED (Month, Day, Year)<br>9-16-90                                       |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>John Tauber 8218 WISCONSIN AVE Bethesda Md.   |  |   |  |   |   |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 17 '90  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randell</i>  |   |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26717

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>John Richard Piagno Jr.  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 13, 1990   |  | 3. TIME OF DEATH<br>10:50 AM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>577-52-4847   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>53 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Aug. 18, 1937   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Washington, D.C.   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>4400 Everett Street  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Kensington  |  |
| 9c. COUNTY OF DEATH<br>Montgomery  |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Montgomery  |  |
| 10c. CITY, TOWN OR LOCATION<br>Kensington  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>4400 Everett Street  |  |
| 10f. ZIP CODE<br>20895   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>2  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Civil Engineer   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>D.C. Government  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John R. Piagno  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Inez (Frari) Piagno   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Virginia W. Piagno   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same as #10   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Gate of Heaven Cemetery  |  | 20c. LOCATION — City or Town, State<br>Silver Spring, Md.  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>DeVol Funeral Home<br>10 East Deer Park Drive<br>Gaithersburg, Maryland 20877  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. Brain metastases  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| b. Cancer of the lung  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| c.   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| d.   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Russell M. Tilley, M.D.   |  |  |  | 29c. LICENSE NUMBER<br>D11888  |  | 29d. DATE SIGNED (Month, Day, Year)<br>Sept. 13, 1990  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Russell Tilley, M.D., 4701 Massachusetts Avenue, N.W., Washington, D.C.   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 17 '90  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2041

71102 02



90 26718

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MARY ELIZABETH   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>September 11 1990   |  |  |  | 3. TIME OF DEATH<br>12:10 A.M.  |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>222-12-3105   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>75 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>2-18-1915                                     |  | 8. BIRTHPLACE (State or Foreign Country)<br>De.   |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Peninsula General Hospital   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Salisbury  |  |  |  | 9c. COUNTY OF DEATH<br>Wicomico   |  |   |  |  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |   |  |   |  |  |  |
| 10a. STATE<br>Md.  |  | 10b. COUNTY<br>Wicomico  |  | 10c. CITY, TOWN OR LOCATION<br>Fruitland  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>102 Camden Avenue  |  |  |  | 10f. ZIP CODE<br>21826  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |  |   |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) 8   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Day Care Provider   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Her Home   |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Thomas Cooper   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Minnie Hill  |  |  |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Cathy R. Hill  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>102 S. Camden Ave. Fruitland, Md. 21826  |  |  |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Odd Fellows Cemetery   |  | 20c. LOCATION — City or Town, State<br>Laurel, De.  |  |  |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>William M. Short  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Short Windsor Disharoon Funeral Home, Inc.<br>P.O. Box 678 Laurel, De. 19956  |  |  |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Lung Cancer<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  | Approximate interval between Onset and Death<br>1 year  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>James E. Martin M.D.  |  |   |  |  |  |   |  | 29c. LICENSE NUMBER<br>030690   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/11/90 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>James E. Martin M.D., 145 E. Carroll St., Salisbury, MD   |  |  |  |   |  |  |  |   |  | 31. DATE FILED (Month, Day, Year)<br>SEP 17 90  |  | 32. REGISTRAR'S SIGNATURE<br>John Brandon      |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

175 176

90 26719

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Michael Joseph Rogers</u>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><u>Sept.</u> <u>19</u> <u>1990</u>  |  | 3. TIME OF DEATH<br><u>9:22 a.m.</u> <u>M</u>   |  |
| 4. SOCIAL SECURITY NUMBER<br><u>089-36-5882</u>   |  | 5. SEX<br><u>1</u> <input checked="" type="checkbox"/> M <u>2</u> <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><u>45</u> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>Dec. 22, 1944</u>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>New York</u>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><u>Western Maryland Center-1500 Pennsylvania Ave.</u>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Hagerstown, Maryland</u>  |  |
| 9c. COUNTY OF DEATH<br><u>Washington</u>  |  |  |  | RESIDENCE OF DECEDENT   |  |   |  |
| 10a. STATE<br><u>Md.</u>  |  | 10b. COUNTY<br><u>Montgomery</u>   |  | 10c. CITY, TOWN OR LOCATION<br><u>Silver Spring</u>   |  | 10d. INSIDE CITY LIMITS?<br><u>1</u> <input checked="" type="checkbox"/> YES <u>2</u> <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><u>10003 Renfrew Rd.</u>  |  |  |  | 10f. ZIP CODE<br><u>20901</u>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>   |  |
| 11. MARITAL STATUS<br><u>1</u> <input type="checkbox"/> Never Married <u>2</u> <input checked="" type="checkbox"/> Married<br><u>3</u> <input type="checkbox"/> Widowed <u>4</u> <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><u>1</u> <input type="checkbox"/> YES <u>2</u> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><u>1</u> <input type="checkbox"/> YES <u>2</u> <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>White</u>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><u>Elementary/Secondary (0-12)</u> <u>College (1-4 or B+)</u>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><u>Scientist</u>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>N.I.H</u>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Robert Rogers</u>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Diana Stelter</u>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Victoria A. Rogers</u>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>10003 Renfrew Rd. Silver Spring, Md. 20901</u>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><u>1</u> <input type="checkbox"/> Burial <u>2</u> <input checked="" type="checkbox"/> Cremation <u>3</u> <input type="checkbox"/> Removal from State<br><u>4</u> <input type="checkbox"/> Donation <u>5</u> <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Smithsburg Crematory</u>  |  | 20c. LOCATION — City or Town, State<br><u>Smithsburg, Md.</u>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Rennis A. Davis</u>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>Davis Funeral Home</u><br><u>Rt 3 Box 78 Smithsburg, Md. 21783</u>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Pneumonia</u>  |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  |  |  |   |  |   |  |
| b. <u>Anoxic encephalopathy</u>   |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| c. <u>Cardiac arrest, post myocardial infarction</u>  |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| d.  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><u>1</u> <input type="checkbox"/> YES <u>2</u> <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><u>1</u> <input type="checkbox"/> YES <u>2</u> <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><u>1</u> <input type="checkbox"/> YES <u>2</u> <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <u>1</u> <input checked="" type="checkbox"/> Inpatient <u>2</u> <input type="checkbox"/> ER/Outpatient <u>3</u> <input type="checkbox"/> DOA<br>OTHER: <u>4</u> <input type="checkbox"/> Nursing Home <u>5</u> <input type="checkbox"/> Residence <u>6</u> <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><u>1</u> <input checked="" type="checkbox"/> Natural <u>5</u> <input type="checkbox"/> Pending Investigation<br><u>2</u> <input type="checkbox"/> Accident<br><u>3</u> <input type="checkbox"/> Suicide <u>6</u> <input type="checkbox"/> Could not be determined<br><u>4</u> <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><u>M</u>   |  | 28c. INJURY AT WORK?<br><u>1</u> <input type="checkbox"/> YES <u>2</u> <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><u>1</u> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><u>2</u> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Fe U. Porciuncula</u>   |  |  |  | 29c. LICENSE NUMBER<br><u>D-12642</u>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>September 19, 1990</u>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Fe U. Porciuncula, M.D. - 1500 Pennsylvania Avenue, Hagerstown, MD 21740</u>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><u>SEP 21 '90</u>  |  | 32. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1942

Continued

Page 5-43

90 26720

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Elsie M. Revelle</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> - DAY <b>14</b> - YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>5:15 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-05-7235</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>90</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>6-4-1900</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Manokin Manor Nursing Home</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Princess Anne</b>  |  | 9c. COUNTY OF DEATH<br><b>Somerset</b>  |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Somerset</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Princess Anne</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>Route 13 &amp; Mt. Vernon Road</b>   |  |  |  | 10f. ZIP CODE<br><b>21853</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Housewife</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>                   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Curtis C. Pusey</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Laura Tull</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. June P. Gourley</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Westover, Md. 21871</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Beechwood Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Pr. Anne, Md. 21853</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i> <b>MO0295</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hinman Funeral Home<br/>Princess Anne, Md. 21853</b>   |  |   |  |
| 23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest.</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>ASLVD, sick sinus syndrome - pacemaker 2 yrs</b><br>c. <b>Colon cancer</b><br>d. <b>Anemia.</b> |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Colon cancer</b><br><b>Anemia.</b>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>C. Stegman M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>225219</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-17-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CHARLES STEGMAN, M.D., Mt. Vernon Road, Princess Anne, Md. 21853</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 17 '90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1

... ..  
... ..  
... ..  
... ..  
... ..

... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..

... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..  
... ..

... ..  
... ..  
... ..  
... ..  
... ..

90 26721

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |                          |  |   |  |   |  |
|---|--|--------------------------|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Galen C. Reynolds</b>  |  |                          |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 13, 1990</b>   |  | 3. TIME OF DEATH<br><b>7:15 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>223-36-8570</b>   |  | 5. SEX<br><b>1 M 2 F</b> |  | 6. AGE (In yrs. last birthday)<br><b>60</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Dec. 6, 1929</b>                 |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>North Carolina</b>   |  |                          |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>13251 Meander Cove Drive</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Germantown</b>                      |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |                          |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Germantown</b>  |  |                          |  | 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>   |  | 10e. STREET AND NUMBER<br><b>13251 Meander Cove Drive</b>                     |  |
| 10f. ZIP CODE<br><b>20874</b>   |  |                          |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 11. MARITAL STATUS<br><b>1 Never Married 2 X Married 3 Widowed 4 Divorced</b> |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><b>1 X YES 2 NO</b><br>IF YES, GIVE WAR OR DATES<br><b>Korean</b>  |  |                          |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 X NO</b> Specify:         |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>12</b>   |  |                          |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Science Technician</b>              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>N. O. A. A.</b>                          |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Grover C. Reynolds</b>  |  |                          |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Stella Shelor</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Eileen B. Reynolds</b>   |  |                          |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13251 Meander Cove Drive, Germantown, MD 20874</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |  |                          |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Suburban Crematory</b>   |  | 20c. LOCATION — City or Town, State<br><b>Silver Spring, Maryland</b>         |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Ellen H. Rapp</b>   |  |                          |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Rapp Funeral Services, P. A.<br/>933 Gist Avenue, Silver Spring, MD 20910</b>                                    |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |                          |  |   |  |   | Approximate Interval Between Onset and Death   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>lung cancer</b>  |  |                          |  |   |  |   | <b>5 mo</b>  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |                          |  |   |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):   |  |                          |  |   |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):   |  |                          |  |   |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):   |  |                          |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                          |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 X NO</b>   |  |                          |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 X NO</b>   |  |                          |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b><br>OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |   |  |
| 27. MANNER OF DEATH<br><b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>   |  |                          |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  |
| 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>   |  |                          |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br><b>1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |                          |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>   |  |                          |  | 29c. LICENSE NUMBER<br><b>D29675</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>September 14, 1990</b>              |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Ralph Boccia, MD</b>  |  |                          |  | 31. DATE FILED (Month, Day, Year)<br><b>SEP 17 '90</b>  |  |   |  |
| 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |                          |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21208-9446

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used for burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26722

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Sally Rabiner</u>  |  |  |  | 2. DATE OF DEATH<br>MONTH <u>09</u> DAY <u>09</u> YEAR <u>90</u>  |  | 3. TIME OF DEATH<br><u>4:25</u> A M  |  |
| 4. SOCIAL SECURITY NUMBER<br><u>139-38-1385</u>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><u>83</u> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><u>3/26/1907</u>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>Austria</u>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><u>Suburban Hospital</u>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Bethesda</u>   |  |
| 9c. COUNTY OF DEATH<br><u>Montgomery</u>  |  |  |  | 10a. STATE<br><u>New Jersey</u>   |  | 10b. COUNTY<br><u>Morris</u>   |  |
| 10c. CITY, TOWN OR LOCATION<br><u>Lake Hiawatha</u>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><u>37 Oneida Avenue</u>  |  |
| 10f. ZIP CODE<br><u>07037</u>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>White</u>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u></u>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><u>Homemaker</u>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Home</u>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Michael Luks</u>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Freda Brunwasser</u>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Anne Lavine (daughter)</u>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>7422 Arrowood Road, Bethesda, MD 20817</u>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>King Solomon Cemetery</u>  |  | 20c. LOCATION — City or Town, State<br><u>Clifton, New Jersey</u>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Frank A. Stone</u>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>Danzansky-Goldberg Memorial Chapels, Inc.<br/>1170 Rockville Pike, Rockville, MD 20852</u>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Stroke</u><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <u>Generalized arteriosclerosis</u><br>c. <u></u><br>d. <u></u> |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Pulmonary Embolism</u><br><u>Coronary Heart Disease</u>  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><u>M</u>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Dr. H. A. ...</u>   |  |  |  | 29c. LICENSE NUMBER<br><u>D02210</u>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>9-9-90</u>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>IRWIN H. ARDAM, D.D. - 5454 WISCONSIN AVE, WASH, DC</u>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><u>SEP 13 '90</u>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><u>John Davidson-Randall</u>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ashby McCLEAN Sellman</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9-5-90</b>   |  | 3. TIME OF DEATH<br><b>1:37PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-16-8432</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10 7 1926</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Prince Georges General Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cheverly</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Prince Georges Co.</b>  |  |  |  | 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>ANNE ARUNDEL</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>LOTHIAN</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>5424 SANDS ROAD</b>   |  |
| 10f. ZIP CODE<br><b>20711</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>  |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>LABORER</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>TRIANGLE TABACCO WAREHOUSE</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ROBERT P. SELLMAN</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY C. GRAY</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ROBERT P. SELLMAN</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5424 SANDS RD. LOTHIAN, MD. 20711</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MOSES CEMETERY</b>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>DRURY, MARYLAND</b>   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Larry H. Reese</i>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>821 WEST ST. ANNAPOLIS, MD. 21401</b><br><b>WILLIAM REESE &amp; SONS MORTUARY, P.A.</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Subdural Hemorrhage</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Seizure disorder and Hypertensive cardiovascular disease</b> |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> INPATIENT <input type="checkbox"/> ER/OUTPATIENT <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> NURSING HOME <input type="checkbox"/> RESIDENCE <input type="checkbox"/> OTHER (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>7-20-90</b>  |  |  |  |
| 28b. TIME OF INJURY<br><b>9:53PM</b>  |  |  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Subject fell to roadside while climbing fence</b>   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>Road</b>   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>1200 Block Mt. Zion/Marlboro Rd. Prince Georges County, MD</b>   |  |  |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Mario F. Golle, Jr.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>9-7-90</b>  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARIO F. GOLLE, JR., MD 111 Penn Street, Baltimore, MD 21201</b>  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEPT 2 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Hudson-Rendell</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11

11-11-11

90 26724

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ellen F. SMITH</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 13 90</b>   |  | 3. TIME OF DEATH<br><b>0300</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-34-9353</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>52</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>07/25/1938</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>DORCHESTER GENERAL HOSPITAL</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>CAMBRIDGE</b>  |  |
| 9c. COUNTY OF DEATH<br><b>DORCHESTER</b>   |  |  |  | 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>DORCHESTER</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>WINGATE</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>2152 WINGATE BISHOPS HEAD ROAD</b>  |  |
| 10f. ZIP CODE<br><b>21675</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE/CAUC.</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b><br>College (1-4 or 5+) <b>PAYROLL OFFICER</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>OFFICE</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>OLIVER FISHER</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>VIRGINIA (MAIDEN NAME UNKNOWN)</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>WILLIAM G. SMITH</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>21675 2152 WINGATE BISHOPS HEAD RD., WINGATE, MD.</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MD. VETERANSCEMOFEAST.SHRE</b>   |  | 20c. LOCATION — City or Town, State<br><b>HURLCOK, MARYLAND</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Colleen Curran-Bramwell</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>CURRAN FUNERAL HOME 21613 308 HIGH STREET, CAMBRIDGE, MD.</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>cardio-pulmonary arrest</b> 1hr  |  |  |  |   |  |  |  |
| b. <b>congestive heart failure</b> 5yrs  |  |  |  |   |  |  |  |
| c. <b>atherosclerotic heart disease</b> 5yrs   |  |  |  |   |  |  |  |
| d. _____   |  |  |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>diabetes mellitis</b>   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Charles M. Briggs, M.D.</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D27184</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>09-13-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 14 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-102

90 26725

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Herman W. Smith   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09 07 90  |  | 3. TIME OF DEATH<br>0505 M  |   |
| 4. SOCIAL SECURITY NUMBER<br>578-18-0209  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>86 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>12-01-03  |   |
| 8. BIRTHPLACE (State or Foreign Country)  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Peninsula General Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Salisbury  |   |
| 9c. COUNTY OF DEATH<br>Wicomico   |  |   |  | 10. RESIDENCE OF DECEDENT   |  |   |   |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Somerset   |  | 10c. CITY, TOWN OR LOCATION<br>Crisfield, MD  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>15 W. Main St.  |  |   |  | 10f. ZIP CODE<br>21817  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>Grade 6 - - -  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Bartender  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Hotel - Restaurant  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>George W. Smith  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Florence Ward  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Beverly Quinn   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>D 2 Lincoln Lane - Dayton, N. J. 08810   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Sunnyridge Memorial Park  |  | 20c. LOCATION — City or Town, State<br>Crisfield, MD  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert N. Bradshaw Jr.</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Bradshaw & Sons Funeral Home<br>306 W. Main St. - Crisfield, MD 21817   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Closed Head Trauma<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Subarachnoid Hemorrhage<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Auto Accident<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br>16 days   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br>08-22-90   |  | 28b. TIME OF INJURY<br>1547M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED<br>2 vehicle collision  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>Md. Ave. - 7th Street   |  |   |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>Crisfield, Maryland   |  | 29a. CERTIFIER<br>(Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John T. Bulkeley</i> Deputy M.E.  |  |   |  | 29c. LICENSE NUMBER<br>D03599   |  | 29d. DATE SIGNED (Month, Day, Year)<br>09-07-90   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>John T. Bulkeley, M.D., 108 Pine Bluff Road, Salisbury, Md. 21801  |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 12 '90   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randell</i>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1942 08

1942 08

1942 08

1942 08

1942 08

1942 08

1942 08

1942 08

1942 08

1942 08

1942 08

1942 08

1942 08

1942 08

1942 08

1942 08

1942 08

1942 08

1942 08

1942 08



90 26726

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Donald R. Sharretts  |  |  |  | 2. DATE OF DEATH<br>MONTH 09 DAY 13 YEAR 1990   |  | 3. TIME OF DEATH<br>12:45AM M  |   |
| 4. SOCIAL SECURITY NUMBER<br>212-12-5112   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>83 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>JULY 3, 1907                                      |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Montgomery General Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Olney  |  | 9c. COUNTY OF DEATH<br>Montgomery  |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |   |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>MONTGOMERY  |  | 10c. CITY, TOWN OR LOCATION<br>SILVER SPRING  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>3576 CHISWICK COURT  |  |  |  | 10f. ZIP CODE<br>20906  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                         |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>FOOD BROKER  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>SHARRETTS & BUSH, INC.  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>RALPH C. SHARRETTS  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MARGARET CAMPBELL  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>DAVID BIGLEY SHARRETTS   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>22 MARGATE ROAD, LUTHERVILLE, MARYLAND 21093   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>METROPOLITAN CREMATORY   |  | 20c. LOCATION — City or Town, State<br>ALEXANDRIA, VIRGINIA   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>David Bigley Sharretts</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>FRANCIS J. COLLINS FUNERAL HOME, INC.<br>500 UNIVERSITY BLVD., W., SIL.SP., MD 20901  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <i>Acute respiratory insufficiency and acidosis</i><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  | Approximate Interval Between Onset and Death<br>12 hrs. |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  |  | b. <i>Acute pneumonia</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  | 12-24 hrs.  |
|  |  | c. <i>End-stage Chronic obstructive pulmonary disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  | 1 yr  |
|  |  | d. <i>Chronic obstructive pulmonary disease</i>  |  |   |  |  | 30 yrs  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Hypertension</i>  |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO     |   |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURED  |  |  |   |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Donald E. Dillon MD</i>  |  |  |  | 29c. LICENSE NUMBER<br>013832   |  | 29d. DATE SIGNED (Month, Day, Year)<br>13 Sept 90  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Donald E. Dillon, MD, 2901 Olney Sandy Spring Rd Olney, MD 20832  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 17 '90  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for filing within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26727

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Robert (NMN) SPON</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 - 12 90</b>  |  | 3. TIME OF DEATH<br><b>9 PM M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>unavailable</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>72 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Sept. 6, 1918</b>                          |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>5480 Wisconsin Avenue</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Chevy Chase</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Montgomery</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Chevy Chase</b>                                    |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>5480 Wisconsin Avenue</b>  |  |  |  |
| 10f. ZIP CODE<br><b>20815</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b><br>College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Military Sgt.</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Air Force (retired)</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>unavailable</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>unavailable</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Rose Mary Gerns</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4701 Willard Avenue Chevy Chase, Maryland 20815</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Alexandria, Virginia</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John F. DeLoe</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DeVol Funeral home<br/>2222 Wisconsin Avenue, NW Washington, D.C.</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>Coronary arteriosclerosis</b><br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br> |  |  |  |   |  |  | Approximate interval between Onset and Death |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John Tamber MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>708546</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-13-90</b>                                |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John Tamber 8218 Wisconsin Ave</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 17 '90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rodell</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26728

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>George R. Spence, M.D.</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 09 90</b>  |  | 3. TIME OF DEATH<br><b>8:50am</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-44-5488</b>   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>FEB. 6, 1914</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>PENNSYLVANIA</b>   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Montgomery General Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Olney</b>  |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  |   |  | 10b. COUNTY<br><b>MONTGOMERY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>SILVER SPRING</b>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>15316 PINE ORCHARD DRIVE, APT. #2A</b>  |  | 10f. ZIP CODE<br><b>20906</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b> |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>6+</b>                                    |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>PHYSICIAN</b>  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>MEDICAL</b>   |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>GEORGE K. SPENCE</b>   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ANNA MARTIN</b>   |  |   |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>EDNA J. SPENCE (WIFE)</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>20906 15316 PINE ORCHARD DRIVE, #2A, SILVER SPRING, MD</b>     |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GATE OF HEAVEN CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>SILVER SPRING, MARYLAND</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James S. Dooley</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W., SIL.SP., MD 20901</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Septicemia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Bacteremia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Arteriosclerotic Cardiovascular Disease</i>  |  |   |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>James S. Dooley</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>MD. 268881</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/5/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BERNARD H. HARRIS, MD 1811 Prince Philip Dr Olney, Md. 20932</b>  |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 13 '90</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3148

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

50+1

100

100

100

1 - FOR  
STATE  
REGISTRAR

**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH** REG. NO.

REG. NO.

|   |  |   |  |  |  |   |  |   |  |  |  |   |  |  |  |
|---|--|---|--|--|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROGER LEE TIMMONS</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>SEPT</b> DAY <b>17</b> YEAR <b>1990</b>   |  |   |  | 3. TIME OF DEATH<br><b>M</b>  |  |  |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-58-0053</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>35</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>DEC. 10, 1954</b> |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Willard</b>  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>400 TRINITY DRIVE</b>  |  |   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>SALISBURY</b>   |  |   |  | 9c. COUNTY OF DEATH<br><b>WICOMICO</b>                         |  |   |  |  |  |
| RESIDENCE OF DECEDENT   |  |   |  |  |  |   |  |   |  |  |  |   |  |  |  |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>WICOMICO</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>MARYLAND</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>400 TRINITY DRIVE</b>  |  |   |  |  |  | 10f. ZIP CODE<br><b>21801</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                    |  |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Afro American</b>              |  |  |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b><br>College (1-4 or 5+) <b></b>  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>laborer/Chef</b>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>English Grill</b>  |  |  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Earl L. Timmons</b>   |  |   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rocedia Fields</b>  |  |   |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dussie Timmons</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7 East Chandler Hqts., Seaford, DE 19956</b>   |  |   |  |   |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Green Acres Memorial Park</b>   |  |   |  | 20c. LOCATION — City or Town, State<br><b>Salisbury, Maryland</b>                               |  |  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Patricia Golley Laskley</i>   |  |   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>JOLLEY MEMORIAL CHAPEL</b><br><b>Rt. #2, Box 920, Jersey Road, Salisbury, Maryland 21801</b> |  |   |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Pulmonary Embolism</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Thrombophlebitis of leg</b><br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |  |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b><br><b>History of Cryptococcal Meningitis</b>   |  |   |  |  |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE HOW INJURY OCCURRED                              |  |   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |  |   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Bonnie J. Chan MD</i>   |  |   |  |  |  | 29c. LICENSE NUMBER<br><b>0-20250</b>   |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/17/90</b>          |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>547-D Riverside Dr. Salisbury, Md 21801</b>   |  |   |  |  |  |   |  |   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 18 90</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Richard Davidson-Randall</i>   |  |   |  |   |  |  |  |   |  |  |  |





90 26730

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>STELLA Lynch TOWNSEND</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9-15-90</b>  |  | 3. TIME OF DEATH<br><b>2108</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>222-18-1117</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>May 23 1909</b>  |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>Peninsula General Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Salisbury</b>   |  | 9c. COUNTY OF DEATH<br><b>Wicomico</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Florida</b>   |  | 10b. COUNTY<br><b>Lee</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Cape Coral</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>4317 S.E. First Avenue</b>  |  |  |  | 10f. ZIP CODE<br><b>33904</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>11</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William T. Hudson</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Emma S. Rodney</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William H. Lynch</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4317 S.E. First Avenue, Cape Coral, Florida 33904</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Roxana Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Roxana, DE</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Charles W. Hastings</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hastings Funeral Home<br/>Selbyville, DE 19975</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>CARDIOPULMONARY ARREST</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>LABORIGENIC SHOCK</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>ACUTE MYOCARDIAL INFARCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>D. Chodnicki M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>P20912</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-15-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DENNIS J. Chodnicki M.D. Locust + Quincy Sts. Salisbury, MD 21801</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 17 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

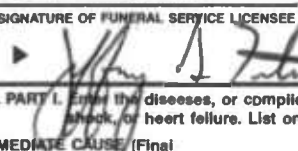
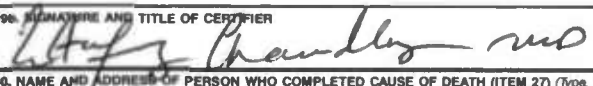



**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

90 26731

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Edwin L. Taylor</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 10, 1990</b>   |  | 3. TIME OF DEATH<br><b>4:12 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-32-2154</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>93</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Nov. 2, 1896</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Shady Grove Adventist Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Potomac</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>12311 Glen Mill Road</b>  |  |  |  | 10f. ZIP CODE<br><b>20854</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW I</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>1</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Builder</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Self Employed</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Alfred Taylor</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Caroline Not Available</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Carol B. Peters</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>12321 Glen Mill Road, Potomac, Maryland 20854</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parklawn Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Rockville, Maryland</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  | M00689   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Md. 20814-3501</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  | Approximate interval between Onset and Death  |  |
| a. <u>Cardiac arrest</u><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| b. <u>Myocardial infarction</u><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| c. <u>Coronary heart disease</u><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| d.   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive Heart Failure</b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 29. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                     |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  | 29c. LICENSE NUMBER<br><b>D 14364</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Sept. 11, 1990</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Mohammad H. Chaudhry, M.D. 8218 Wisconsin Avenue #107, Bethesda, Maryland 20814</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 13 '90</b>   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26732

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Ernest N. Troubridge</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>9</i> DAY <i>9</i> YEAR <i>90</i>  |  | 3. TIME OF DEATH<br><i>10A</i> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>42-4-3771</i>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs., last birthday)<br><i>70</i> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>June 20, 1914</i>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>Connecticut</i>   |  |  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Anne Arundel Medical Center</i>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Annapolis</i>   |  | 9c. COUNTY OF DEATH<br><i>Anne Arundel</i>  |  |
| 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Anne Arundel</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Annapolis</i>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><i>2610 Quiet Water Cove</i>   |  |  |  | 10f. ZIP CODE<br><i>21401</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (13-16 or 5+) <i>College</i>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Homemaker</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Home</i>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Chester E. Nichols</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Dorothea ---</i>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Mary B. Haldane</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>114 Friendly Lane, Wilmington, NC 28409</i>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Metropolitan Crematory</i>  |  | 20c. LOCATION — City or Town, State<br><i>Alexandria, VA</i>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Jeffrey S. Taylor</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Taylor Funeral Chapel 21401<br/>147 Gloucester St., Annapolis, MD</i>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Basal meningitis, metastatic</i><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><i>a fever</i><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
|  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Stephen Hiltabidle M.D.</i>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9/9/90</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Stephen Hiltabidle, M.D. 801 Melvin Ave., Annapolis, MD 21401</i>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year) <i>SEP 11 1990</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26733

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Yvonne B. Woodham</u>   |  |  |  | 2. DATE OF DEATH<br>MONTH <u>9</u> DAY <u>9</u> YEAR <u>90</u>  |  | 3. TIME OF DEATH<br>M  |  |
| 4. SOCIAL SECURITY NUMBER<br><u>473-18-9977</u>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><u>69</u> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><u>July 1, 1921</u>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>Minnesota</u>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><u>Anne Arundel Medical Center</u>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Annapolis</u>  |  |
| 9c. COUNTY OF DEATH<br><u>Anne Arundel</u>   |  |  |  | 10a. STATE<br><u>Maryland</u>   |  | 10b. COUNTY<br><u>Anne Arundel</u>   |  |
| 10c. CITY, TOWN OR LOCATION<br><u>Annapolis</u>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><u>507 Harbor Drive</u>  |  |
| 10f. ZIP CODE<br><u>21403</u>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><u>W W II</u>  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>White</u>   |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>College</u>   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><u>Homemaker</u>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Home</u>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>Lemeul Tilton</u>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Alma Lane</u>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>James Thomas Woodham</u>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>507 Harbor Drive, Annapolis, MD 21403</u>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Metropolitan Crematory</u>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><u>Alexandria, VA</u>   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Donald J. Taylor</u>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><u>Taylor Funeral Chapel</u> <u>21401</u><br><u>147 Gloucester St., Annapolis, MD</u>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>CA LUNG</u><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Tobacco abuse</u>   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br>M  |  |  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Wm. J. Dabbs</u> <u>MD</u>  |  |  |  |
| 29c. LICENSE NUMBER<br><u>D24768</u>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>9/9/90</u>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>AAMC</u> <u>DR. DABBS</u>  |  |  |  | 31. DATE FILED (Month, Day, Year)<br><u>SEP 11 1990</u>   |  |  |  |
| 32. REGISTRAR'S SIGNATURE<br><u>J. K. Henderson</u>  |  |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000



90 26734

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Dorothy R. Warfield  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 12, 1990   |  | 3. TIME OF DEATH<br>11:00 P M  |   |
| 4. SOCIAL SECURITY NUMBER<br>220-03-0518   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>79 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Apr. 15, 1911   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>7847 Leymar Rd.  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Glen Burnie   |   |
| 9c. COUNTY OF DEATH<br>Anne Arundel  |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Anne Arundel  |   |
| 10c. CITY, TOWN OR LOCATION<br>Glen Burnie   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>7847 Leymar Rd.  |   |
| 10f. ZIP CODE<br>21060   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Chief Telephone Operator   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>C&P Telephone  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Max R. Eschenbach   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Jeanettia Lowman  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Gloria L. Frank  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>103 2nd Ave. S.E., Glen Burnie, Maryland 21061  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Glen Haven Mem. Pk.  |  | 20c. LOCATION — City or Town, State<br>Glen Burnie, A.A., MD   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Kirkley Funeral Home<br>421 Crain Hwy. S.E., Glen Burnie, MD 21061   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acute Myocardial Infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>Arteriosclerotic Heart Disease</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>Diabetes mellitus</i> |  |  |  |  |  |  | Approximate interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |   |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br>D16208  |  | 29d. DATE SIGNED (Month, Day, Year)<br>Sept. 14, 1990  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Jose M. Presbitero, M.D. 7845 Oakwood Rd., Glen Burnie, Maryland 21061  |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>SEP 14 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

13

CONFIDENTIAL

90 26735

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ralph Leonard Wolfe</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 9 1990</b>   |  | 3. TIME OF DEATH<br><b>9:40 a.m.</b>                                       |  |
| 4. SOCIAL SECURITY NUMBER<br><b>232-24-0657</b>   |  | 5. SEX<br><b>1 M 2 F</b>   |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 16, 1910 WV.</b>            |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Garrett County Memorial Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Oakland</b>   |  | 9c. COUNTY OF DEATH<br><b>Garrett</b>                                      |  |
| 10a. STATE<br><b>Md.</b>  |  | 10b. COUNTY<br><b>Garrett</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Rt. 2 Oakland</b>   |  | 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>                              |  |
| 10e. STREET AND NUMBER<br><b>Rt. 2 Box 199</b>  |  |  |  | 10f. ZIP CODE<br><b>21550</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                |  |
| 11. MARITAL STATUS<br><b>1 NEVER MARRIED 2 MARRIED 3 WIDOWED 4 DIVORCED</b>   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b><br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 NO</b> Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 8th</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Farmer</b>                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Farming</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Summers Wolfe</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Carrie Wotring</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Helen Wolfe</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Rt. 2 Box 199 Oakland, Md. 21550</b>      |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Red House Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Oakland, Md.</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hinkle Funeral Home<br/>Box 186 Davis, WV. 26260</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |  | Approximate Interval Between Onset and Death   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrhythmia</b>   |  |  |  |   |  |  | Minutes  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| b. <b>Ischemic Heart Disease</b>  |  |  |  |   |  |  | Years  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| c. <b>Arteriosclerotic Cardio-Vascular Disease</b>  |  |  |  |   |  |  | Unknown  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| d.  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Has had several small CVA's</b>  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 NO</b>   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b> |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 NO</b>   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |   |  |  |  |
| 27. MANNER OF DEATH<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>                                  |  |
|   |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>D 05658</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>September 9, 1990</b>            |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Herbert H. Leighton, M.D., Oak @ 5th Sts., Oakland, Maryland, 21550</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 25 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

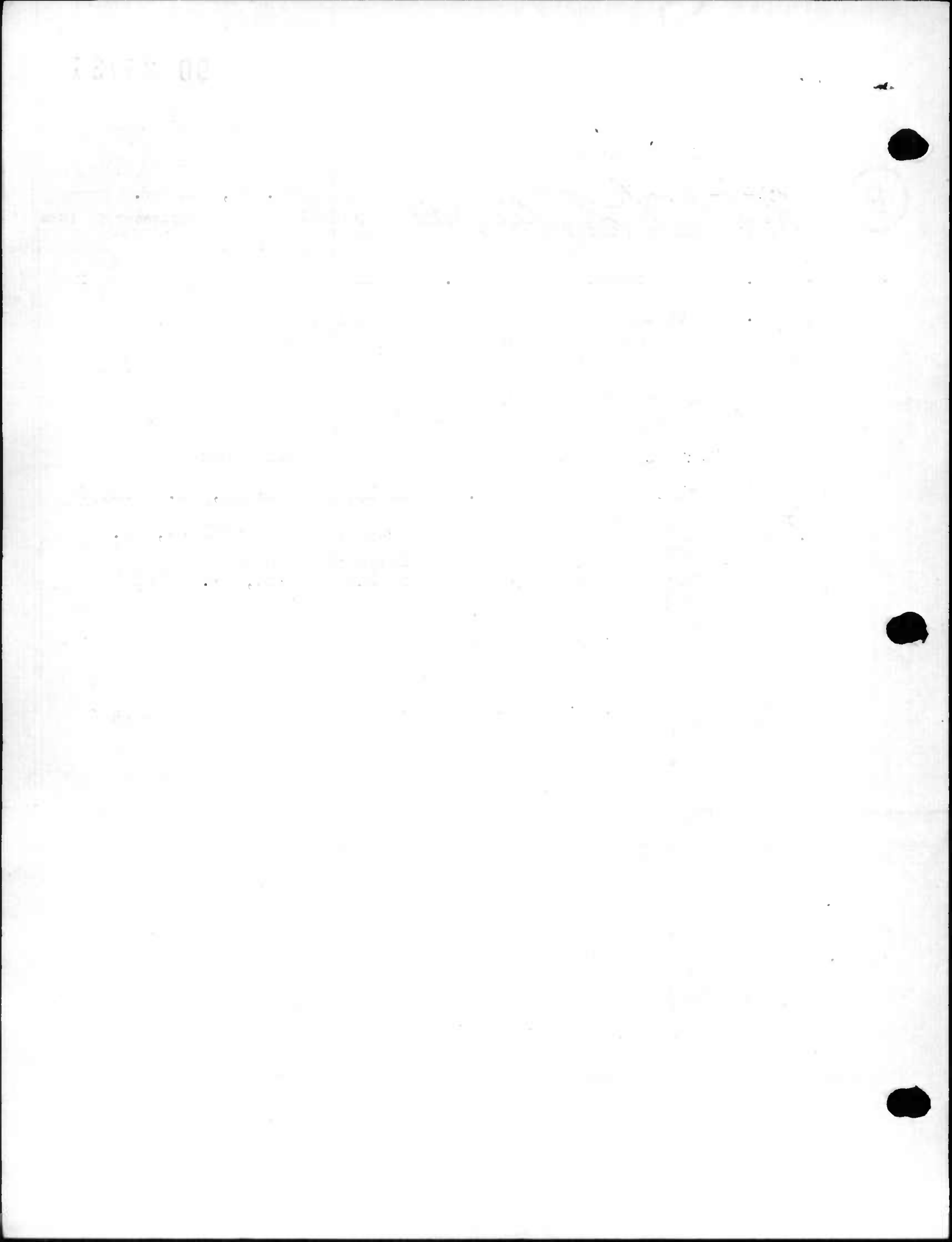
BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26736

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Henry Mahlon Wolfe  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 20 1990   |  | 3. TIME OF DEATH<br>1210 P.M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>215-34-3942  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>54 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>10-25-35  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Frederick Memorial Hospital   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick  |  |
| 9c. COUNTY OF DEATH<br>Frederick  |  |  |  | 10a. STATE<br>Maryland  |  |   |  |
| 10b. COUNTY<br>Frederick  |  |  |  | 10c. CITY, TOWN OR LOCATION<br>Myersville   |  |   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br>4611 Fishers Hollow Road  |  |   |  |
| 10f. ZIP CODE<br>21773  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Maintenance   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>County Roads  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Daniel Wolfe   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Alice Stahl   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Lola Wolfe  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>20400 Frederick Rd G-6, Germantown, MD 20876   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Harmony Ch of Brethren   |  | 20c. LOCATION — City or Town, State<br>Harmony, MD  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Larry L. Ricketts</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>504 Main St.<br>Ricketts Funeral Home Myersville, MD  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metastatic Lung Carcinoma</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Dehydration and Anemia</i>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br>9-20-90   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. Christopher Fleming MD</i>   |  |  |  | 29c. LICENSE NUMBER<br>D37178   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-20-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>J. Christopher Fleming MD, 610 N. 1st Ave. Brunswick, MD, 21716  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 21 '90   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Pondell</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR<br>STATE<br>REGISTRAR  |  |  |   | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO.  |  |  |  |
|---|--|--|---|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>David G. Whittington Sr.  |  |  |   |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-12-90   |  | 3. TIME OF DEATH<br>9:55 p. M   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>214-12-6398  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>77 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Feb 17, 1913   | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland |   |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Edw.W.McCready Memorial Hospital  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Crisfield   |  | 9c. COUNTY OF DEATH<br>Somerset   |  |   |  |  |  |
| RESIDENCE OF DECEDENT   |  |  |   |  |  |   |  |   |  |  |  |
| 10a. STATE<br>Md.   |  | 10b. COUNTY<br>Somerset  |   | 10c. CITY, TOWN OR LOCATION<br>Marion Sta  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>Rt. 1 Box 44 Marion Sta., Md  |  |  |   | 10f. ZIP CODE<br>21838   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                                    |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Seafood Worker Farmer           |   | 16b. KIND OF BUSINESS/INDUSTRY<br>oyster Shucker   |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>David Whittington  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Louise Whittington   |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Wallace Whittington   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Rt. 1 Marion Sta., Md.  |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Family Cemetery  |   | 20c. LOCATION — City or Town, State<br>Marion Sta., Md.  |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Norma J. Ward  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Norma Ward's Funeral Home, Marion, Md.   |  |   |  |   |  |  |  |
| 23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma Prostate with<br>metastases to Bones, liver, lung<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>Renal failure |  |  |   |  |  |   |  | Approximate Interval Between Onset and Death<br>2 yrs.<br>days.   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Nomicide   |  |  |   | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO           |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |   |  |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>M. D. Barhan   |  |  |   |  |  | 29c. LICENSE NUMBER<br>12764  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/12/90  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. M. D. Barhan, Rt. #413, Crisfield, Md. 21817   |  |  |   |  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 18 '90   |  |  |   | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Rendell   |  |   |  |   |  |  |  |

*[Faint, illegible handwritten notes or bleed-through from the reverse side of the page.]*



90 26738

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Thelma Smith Walker</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 11, 1990</b>  |  | 3. TIME OF DEATH<br><b>9:00 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-24-6939</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>6/21/1898</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Manokin Manor Nursing Home</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Princess Anne</b>  |  | 9c. COUNTY OF DEATH<br><b>Somerset</b>  |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Somerset</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Princess Anne</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER   |  |  |  | 10f. ZIP CODE<br><b>21853</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (14 or 6+) <b>Housewife</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>George T. Smith</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Betty Hall</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>William Sharpless</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Edgehill Ter. Route 1</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Grable Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Princess Anne, Md.</b>                                    |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James L. Hinner</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hinman Funeral Home<br/>127 Somerset Ave., Princess Anne, Md.</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebral aneurysm</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF): <b>Senile dementia</b><br>b. DUE TO (OR AS A CONSEQUENCE OF): <b>CVA</b><br>c. DUE TO (OR AS A CONSEQUENCE OF): <b>Pneumonia</b><br>d. |  |  |  |  |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 28a. DATE OF INJURY (Month, Day, Year)  |  |
| 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>ET Gull MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D15081</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-17-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ET Gull MD Manokin Manor, Princess Anne MD</b>   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 13 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Pandell</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3746

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26739

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>CHANNA WEINBERG   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09 12 90  |  | 3. TIME OF DEATH<br>2:45 A.M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>141-24-9546  |  | 6. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>59 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>04-11-31   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>4701 Willard Ave.,  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>CHEVY CHASE  |  | 9c. COUNTY OF DEATH<br>MONTGOMERY   |  |
| 10a. STATE<br>MARYLAND  |  | 10b. COUNTY<br>MONTGOMERY  |  | 10c. CITY, TOWN OR LOCATION<br>CHEVY CHASE  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10a. STREET AND NUMBER<br>4701 WILLARD AVENUE #205  |  |  |  | 10f. ZIP CODE<br>20815  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) 5+  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>ECONOMIST   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>BANK OF ISRAEL  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>BENJAMIN LUTSKY  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>JARA KESSLER   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Jeshajahu Weinberg  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same as #10  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Kibbutz Afek   |  | 20c. LOCATION — City or Town, State<br>Israel   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Ives-Pearson Funeral Homes<br>Falls Church, Va. 22046   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE 10 YRS<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|   |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |  | 29c. LICENSE NUMBER<br>D09290   |  | 29d. DATE, SIGNED (Month, Day, Year)<br>9/12/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>2201 L ST NW WASH. DC  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>SEP 13 '90   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3446  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1977 06

90 26740

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LEONARD NICHOLAS WEIGNER</b>  |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept 7 1990</b>  |  | 3. TIME OF DEATH<br><b>9:30 AM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>127-09-2610</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11-6-1917</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Russia</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Malcolm Grow Medical Center</b>   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Andrews AFB</b>                                       |  | 9c. COUNTY OF DEATH<br><b>Prince Georges</b>   |  |
| 10a. STATE<br><b>Virginia</b>  |  | 10b. COUNTY<br><b>Fairfax</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Falls Church</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |  |  |
| 10e. STREET AND NUMBER<br><b>6601 Dearborn Drive</b>   |  |  |  | 10f. ZIP CODE<br><b>22044</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Caucasian</b>                  |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (8-12) College (1-4 or 5+)<br><b>2</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Pilot</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Military</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Nicholas Weigner</b>   |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Stcherbinsky</b>                   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Anastasia Weigner</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6601 Dearborn Dr., Falls Church, VA 22044</b>   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arlington National Cem</b>  |  | 20c. LOCATION — City or Town, State<br><b>Arlington, VA</b>   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Demaine Funeral Homes, Inc<br/>Alexandria, Virginia 22314</b>  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>Uremia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Ischemic Cardiomyopathy</b><br><b>Chronic Renal Insufficiency</b><br><b>Pseudomonas Pneumonia</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Ischemic Cardiomyopathy</b><br><b>Chronic Renal Insufficiency</b><br><b>Pseudomonas Pneumonia</b>   |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> <b>CERTIFYING PHYSICIAN:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> <b>MEDICAL EXAMINER:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  |   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7 Sep 90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>WILLIAM J. VALKO, CAPT, USAF, MC</b><br><b>Malcolm Grow USAF Medical Center<br/>Andrews AFB MD 20331-5300</b>  |  |  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 14 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the funeral transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

04055 02

90 26741

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Robert J. Werner</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept 13, 1990</b>   |  | 3. TIME OF DEATH<br><b>1401</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>579-26-8840</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>92</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>APR. 22, 1898</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>WEST VIRGINIA</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Calvert Memorial Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Prince Frederick</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Calvert</b>  |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>CHARLES</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>CHARLOTTE HALL</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>MARYLAND VETERANS HOME</b>  |  |
| 10f. ZIP CODE<br><b>20622</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW I</b>  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>2</b>   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>PROPRIETOR AUTO LIST CO.</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>THEODORE WERNER</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MINNIE KINDELBERGER</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>ROBERT S. WERNER (SON)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3423 ISLAND CREEK COURT SILVER SPRING, MD. 20906</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)                                      |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT. OLIVET CEMETERY</b>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>WASHINGTON, D.C.</b>   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert H. Hachery</i>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>FRANCIS J. COLLINS FUNERAL HOME, INC.<br/>500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901</b>   |  |  |  | 23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>GI BLEED</b><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |
| 24. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>9/13/90</b>   |  |  |  |
| 28b. TIME OF INJURY<br><b>M</b>  |  |  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Charles Judge M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D29657</b>   |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>9/13/90</b>  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Charles Judge M.D. Prince Frederick, Maryland</b>  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 17 '90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Page 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

341





90 26742

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>JOSEPH F. ATKINSON  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>SEPT. 29, 1990  |  | 3. TIME OF DEATH<br>11:40 P. M  |   |
| 4. SOCIAL SECURITY NUMBER<br>218-10-0394  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>79 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>MARCH 30, 1911  |   |
| 8a. FACILITY NAME (If not institution, give street and number)<br>624 ORPINGTON ROAD  |  |   |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  | 8c. COUNTY OF DEATH<br>BALTIMORE  |   |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |   |   |
| 10a. STATE<br>MARYLAND  |  | 10b. COUNTY<br>BALTIMORE  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>624 ORPINGTON ROAD  |  |   |  | 10f. ZIP CODE<br>21229  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                                    |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>LETTER CARRIER   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>U.S. POSTAL SERVICE   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOSEPH ATKINSON  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>BERTHA M. KLINESMITH   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>TRESSIE ATKINSON  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>624 ORPINGTON ROAD, BALTIMORE, MARYLAND 21229  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>CRESTLAWN CEMETERY  |  | 20c. LOCATION — City or Town, State<br>MARIOTTSTVILLE, MD.  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES<br>1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Emphysema Compens</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
|   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |   |  | 29c. LICENSE NUMBER<br>A24356   |  | 29d. DATE SIGNED (Month, Day, Year)<br>10/1/90  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>WILLIAM WATERFIELD M.D. 900 CATON AVENUE 3rd FLOOR TOWER BLD., BALTIMORE, MD. 21229  |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>OCT 01 1990  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26743

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARGARET BARKER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 27 90</b>   |  | 3. TIME OF DEATH<br><b>8:35A M</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>578-26-6040</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12-19-18</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>VIRGINIA</b>  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Liberty Med. Center</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH   |   |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>1905 Lauretta Ave.</b>  |  | 10f. ZIP CODE<br><b>21223</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                          |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Merlun Holmes</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Annie Mitchell</b>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Barbara Taylor</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2101 Resbury St. Balto. Md. 21217</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT Zion Cem.</b>  |  | 20c. LOCATION — City or Town, State<br><b>Balto. Co. Md.</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph L. Russ</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph L. Russ Funeral Home<br/>8222 W. North Ave. Balto. Md. 21216</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA with SEPSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>CEREBRO-VASCULAR ACCIDENT</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>FRACTURE LT. FEMUR</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DIABETES MELLITUS</b><br><b>EXOGENOUS OBESITY</b><br><b>HYPERTENSION</b>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Joseph L. Russ MD.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D 23300</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9.27.90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SUDHIR D. PATEL 2600 Liberty Rd. BALTO. MD. 21215</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |  |  |   |  |
|--|--|--|---|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Steven Robert Brown  |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-23-90  |  | 3. TIME OF DEATH<br>11:02PM M   |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>49 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>11-9-1950  | 8. BIRTHPLACE (State or Foreign Country)<br>New York |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Sinai Hospital   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City  |  | 9c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT  |  |  |   |  |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY  |   | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>3302 AURORA AVE. Apt E.  |  | 10f. ZIP CODE<br>21207   |   | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Instructor  |   | 16b. KIND OF BUSINESS/INDUSTRY<br>School   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Harry Brown   |  |  |   | 18. MOTHER'S NAME (First, Middle, Last)<br>Pearl Smith   |  |   |  |
| 19a. INFORMANT'S NAME (Type/print)<br>Mrs. Sensinta Brown  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5604 Hereford Ct Alexandria Va. 22313   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Western Star Cem.  |   | 20c. LOCATION — City or Town, State<br>BALTD. Co. Md   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Joseph L. Russ  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Joseph L. Russ Funeral Home<br>2223 W. North Ave. Balt. Md. 21216  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple gunshot wounds<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |   |  |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>XX YES 2 <input type="checkbox"/> NO   |
|  |  |  |   |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>XX YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input checked="" type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>9-23-90  |   | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES XX NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>Subject shot  |   | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>Street   |  |   |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>5600 block Haddon Ave. Baltimore, Maryland   |   |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>ANN M. DIXON, MD  |  |  |   | 29c. LICENSE NUMBER<br>OCME  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-24-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>ANN M. DIXON, MD 111 Penn Street, Baltimore, MD 21201   |  |  |   |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 01 1990   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |   |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


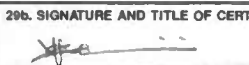
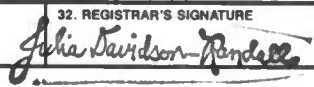
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26745

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MILTON ANDREW BAUER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>30</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>12:05 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-10-7053</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>83</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>February 7, 1907</b>                                  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  |   |  | 9c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Md</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>2358 Washington Blvd.,</b>  |  |  |  | 10f. ZIP CODE<br><b>21230</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th Grade</b><br>College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Inspector-Plumbing</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>City Government</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Unknown</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Unknown</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Carrie L. Bauer</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2358 Washington Blvd., Baltimore, Md. 21230</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>London Park Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hubbard Funeral Home Inc.<br/>4107 Wilkens Avenue, Baltimore, Md. 21229</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PARKINSON'S DISEASE</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. <b>ASPIRATION PNEUMONIA</b><br>c. <b>DUE TO (OR AS A CONSEQUENCE OF):</b><br>d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> <b>ASWANI YESOU, MD</b>   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ASWANI YESOU, ST. AGNES HOSP. 900 CATHOLIC AVE. BALTO MD 21229</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours of a death. Page 6 may be retained by the hospital or attending physician TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26746

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Edwin Mayer Bosley</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 27 1990</b>  |  | 3. TIME OF DEATH<br>M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-16-5715</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Oct. 19 1907</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>10715 Lancewood Road</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cockeysville</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Cockeysville</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>10715 Lancewood Road</b>  |  |
| 10f. ZIP CODE<br><b>21030</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Painter</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Ft. Meade</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Aquilla C. T. Bosley</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Maria Eliza Hahn</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Margaret Bosley</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10715 Lancewood Road, Cockeysville, Md, 21030</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Thomas Episcopal Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Owings Mills, Md.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Paul T. Sochlamper</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lemmon-Mitchell-Wiedefeld Timonium, Maryland</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute cardiovascular insufficiency</i><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| b. <i>Carcinomatous - boxes, lung, liver involvement</i><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| c.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| d.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robert W. Lisle</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D14318</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/28/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Robert W. Lisle, M.D. 57 W. Timonium Rd., Timonium, Md.</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rendall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26747

FOR  
STATE  
REGISTRAR **Amelia Bane Billups** **STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH** REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Amelia B. Billups</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>20</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>0820A</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>364-46-2493</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Feb. 21, 1907</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Washington, D.C.</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Leland Memorial Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Riverdale</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Prince George</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Prince George</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Riverdale</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>5309-Riverdale Road, #401</b>   |  |
| 10f. ZIP CODE<br><b>20737</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Analyst</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Defence Department</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Edgar Milton Bane</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mabel E. Burton</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Linda E. Davis</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>448-N St., NW, Washington, D.C. 20001</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>  |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>Suitland, Maryland</b>  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Charles L. Belanger</b>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>J. William Lee's Sons Company Funeral Home<br/>300-4th St., NE, Washington, DC 20002-5816</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Atherosclerotic Heart Disease</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Right Lower Lobe Pneumonia</b><br><br><b>ORGANIC BRAIN SYNDROME</b><br><b>DECUBITUS ULCERS</b><br><b>Electrolyte Imbalance</b> |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>Feb. 21, 1990</b>  |  |  |  |
| 28b. TIME OF INJURY<br><b>M</b>   |  |  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Michael P. Moran, MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 36860</b>   |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>9/20/90</b>   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Michael P. Moran, MD 7610-Carroll Ave., Takoma Park, Maryland</b>   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |  |  |



90-26748  
90 26748

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |   |
|--|--|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>RAYMOND BARTON   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9 27 90  |  | 3. TIME OF DEATH<br>9:20 A M  |   |
| 4. SOCIAL SECURITY NUMBER<br>047-05-9669   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>77 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>5-1-13   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Connecticut  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>UNION MEMORIAL HOSPITAL  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |   |
| 9c. COUNTY OF DEATH  |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Baltimore  |   |
| 10c. CITY, TOWN OR LOCATION<br>White Marsh   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>5821 Lytle Rd.  |   |
| 10f. ZIP CODE<br>21162   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |   |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12 yrs.   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Insurance Inspector   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Harford Steam Boiler Insp. and Insurance Company   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>William J. Barton   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Kate Louise Mossman   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>William J. Barton  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>35 Elmont Avenue Baltimore, Maryland 21206  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Metro Crematory, Inc.  |  | 20c. LOCATION — City or Town, State<br>Baltimore, Maryland   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>E. J. Davidson Jr.</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>7401 Belair Rd Balto., Md. 21236   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |   | Approximate Interval Between Onset and Death<br>1 mm<br>immed<br>73 years |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <i>cardiac arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |   |   |
| b. <i>multiple MI</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |   |   |
| c. <i>CAD</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |   |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>d.   |  |  |  |  |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   |   |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>B. Beel</i>  |  |  |  | 29c. LICENSE NUMBER<br>D222789   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/27/90  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)<br>STUART B. Beel m 3501 S. Pine St Balto Md   |  |  |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>OCT 1 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be returned to the State Dept. of Health and Mental Hygiene as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26749

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |   |
|---|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HOWARD H. BERODT</b>   |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>25</b> YEAR <b>1990</b>  |   | 3. TIME OF DEATH<br><b>11:30 P M</b>  |
| 4. SOCIAL SECURITY NUMBER<br><b>481-12-0403</b>   | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>68</b> YRS.   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>OCT. 14, 1921</b>  | 8. BIRTHPLACE (State or Foreign Country)<br><b>IOWA</b>   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>10065-4 WINDSTREAM DRIVE</b>   |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>COLUMBIA</b>   |   | 9c. COUNTY OF DEATH<br><b>HOWARD</b>  |
| RESIDENCE OF DECEDENT   |  |  |  |   |   |
| 10a. STATE<br><b>MARYLAND</b>   | 10b. COUNTY<br><b>HOWARD</b>   | 10c. CITY, TOWN OR LOCATION<br><b>COLUMBIA</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |   |
| 10e. STREET AND NUMBER<br><b>10065-4 WINDSTREAM DRIVE</b>   |  | 10f. ZIP CODE<br><b>21044</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |   |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |  |  |   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>U.S. AIR FORCE</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>MILITARY</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>HERMAN BERODT</b>   |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>AMANDA SIEBKE</b>  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>LOIS BERODT</b>  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10065-4 WINDSTREAM DRIVE, COLUMBIA, MARYLAND 21044</b> |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ARLINGTON NATIONAL CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>ARLINGTON, VIRGINIA</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy M. &amp; Russell C. Witzke</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROEY M. &amp; RUSSELL C. WITZKE FUNERAL HOMES<br/>5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>NON-AT CELL CARCINOMA OF RIGHT LUNG</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Approximate Interval Between Onset and Death<br><b>3 mos</b> |  |  |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b>  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
|   |  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   | 28b. TIME OF INJURY<br><b>M</b>  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  | 28d. DESCRIBE HOW INJURY OCCURRED   |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>James A. Brown MD</i>   |  |  | 29c. LICENSE NUMBER<br><b>007285</b>   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/26/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JAMES A. BROWN MD 14808 PHYLICIAN LANE ROCKVILLE, MD 20850</b>  |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Jake Davidson-Randall</i>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |  |   |   |  |
|--|--|---|--|---|--|--|---|---|--|
| CERTIFICATE OF DEATH   |  |   |  |   |  |  |   |   |  |
| REG. NO.   |  |   |  |   |  |  |   |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>WILLIAM F. BURKE, SR.  |  |   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09 27 90                                       |   | 3. TIME OF DEATH<br>5:00 P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>212-12-9910   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>70 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>07 09 20                                   |   | 8. BIRTHPLACE (State or Foreign Country)<br>VIRGINIA  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>3521 HICKORY AVENUE  |  |   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE                                     |   | 9c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |  |   |   |  |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  |  |   | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>3521 HICKORY AVENUE  |  |   |  | 10f. ZIP CODE<br>21211  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |   |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW II   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8TH<br>College (1-4 or 5+)   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>TRUCK DRIVER   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>OPERATORS HEAT                                     |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>GEORGE BURKE  |  |   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MARY BURKE                      |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>MARY SUSAN CARNES  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3521 HICKORY AVENUE, BALTIMORE, MD. 21211  |  |  |   |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>OAKLAWN CEMETERY  |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MARYLAND                           |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Rich. Chang</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>A. ALAN SEITZ, JR. FUNERAL HOME<br>3615-19 CHESTNUT AVENUE, BALTO., MD. 21211   |  |  |   |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |  |  |   |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Shock</i>  |  |   |  |   |  |  |   |   |  |
| b. <i>Ruptured Aneurysm</i>  |  |   |  |   |  |  |   |   |  |
| c. <i>Hypertension</i>   |  |   |  |   |  |  |   |   |  |
| d.   |  |   |  |   |  |  |   |   |  |
| Approximate Interval Between Onset and Death<br><i>minute</i><br><i>years</i>  |  |   |  |   |  |  |   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Hypertension</i>  |  |   |  |   |  |  |   |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |  |   |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |   |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |  |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>A. C. Williams, M.D. Attending</i>   |  |   |  |   |  | 29c. LICENSE NUMBER<br>016365  |   | 29d. DATE SIGNED (Month, Day, Year)<br>9/28/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>B. Cochran, M.D. 846 W. 36th St. Balt., MD 21211  |  |   |  |   |  |  |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 10 1990   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |  |  |   |   |  |



ITEM:4 per FH G-668  
10-26-90 cm

90 26751

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |   |   |                          |   |  |   |   |  |
|---|--|--|---|---|--------------------------|---|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARGARET E. CHILES</b>   |  |  |   | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>27</b> YEAR <b>90</b>   |                          | 3. TIME OF DEATH<br><b>7:00 P</b>   |  |   |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>371-09-2791</b><br><b>212-60-4809</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |   | 6. AGE (In yrs. last birthday)<br><b>43</b> YRS.  |                          | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>12-30-1946</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>       |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SAINT JOSEPH HOSPITAL</b>  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |                          |   |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                           |   |  |
| RESIDENCE OF DECEDENT   |  |  |   |   |                          |   |  |   |   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  |  | 10b. COUNTY<br><b>BALTIMORE</b>   |   |                          | 10c. CITY, TOWN OR LOCATION<br><b>CARNEY</b>  |  |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>8706 LOCKBEND ROAD</b>   |  |  |   |   |                          | 10f. ZIP CODE<br><b>21234</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                    |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |   |                          | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b><br>College (1-4 or 5+) <b>N/A</b>  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>   |   |                          | 16b. KIND OF BUSINESS/INDUSTRY<br><b>HOME</b>   |  |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>(UNKNOWN) SCHARNAGLE</b>  |  |  |   |   |                          | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>(UNKNOWN)</b>   |  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARGARET PARR (NIECE)</b>  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2616 CRAB APPLE ROAD, BALTIMORE, MARYLAND 21234</b> |                          |   |  |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |   | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BALTIMORE NATIONAL CEMETERY</b>  |                          |   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b> |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Eugene J. Last...</i>   |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br><b>SCHIMUNEK FUNERAL HOME, INC.</b><br><b>9705 BELAIR ROAD, BALTIMORE, MARYLAND 21236</b>                           |                          |   |  |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE MYOCARDIAL INFARCTION.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |  |   |   |                          |   |  |   |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                          |   |  |   |   |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
|   |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |   |                          |   |  |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |   |                          |   |  |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Ceballos, MD</i>  |  |  |   | 29c. LICENSE NUMBER<br><b>D 25886</b>   |                          | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/27/90</b>   |  |   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CEBALLOS, M.D. — ST. JOSEPH HOSPITAL - TOWSON, MD</b>   |  |  |   |   |                          |   |  |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b><br>REGISTRAR'S SIGNATURE<br><i>Jane Davidson-Randall</i>  |  |  |   |   |                          |   |  |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached to the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transmittal. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |   |                                | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 90 26752  |  |  |  |
|---|--|---|--------------------------------|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |   |                                | 2. DATE OF DEATH<br>MONTH DAY YEAR  |  |  |  | 3. TIME OF DEATH  |  |  |  |
| WILLIAM B CREE  |  |   |                                | 09 25 90  |  |  |  | 11:05 P <sup>M</sup>  |  |  |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX  | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.                               |  | 7. DATE OF BIRTH<br>(Month, Day, Year)  |  | 8. BIRTHPLACE (State or Foreign Country) |  |
| 220 42 6652   |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 48 YRS.                        | MONTHS DAYS   |  | HOURS MIN.                                     |  | 09/02/42  |  | Pennsylvania                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |   |                                | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |  |  | 9c. COUNTY OF DEATH   |  |  |  |
| GREATER BALTIMORE MEDICAL CENTER  |  |   |                                | TOWSON  |  |  |  | BALTIMORE   |  |  |  |
| 10a. STATE  |  |   |                                | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION                    |  | 10d. INSIDE CITY LIMITS?  |  |  |  |
| MD  |  |   |                                | BALTIMORE   |  | MONKTON  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |
| 10e. STREET AND NUMBER  |  |   |                                | 10f. ZIP CODE   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?   |  |  |  |
| 902 MONKTON ROAD  |  |   |                                | 21111   |  |  |  | U.S.A.  |  |  |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?   |                                | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)   |  | 14. RACE — American Indian, Black, White, etc. |  |   |  |  |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>Vietnam |                                | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | Specify:<br>White                              |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)  |  |   |                                | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| Elementary/Secondary (0-12)<br>12   |  |   |                                | College (1-4 or 5+)   |  |  |  | Engineer<br>Construction  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |   |                                | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |  |  |   |  |  |  |
| Robert Cree   |  |   |                                | Mildred Carberry  |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |   |                                | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |  |  |  |   |  |  |  |
| Maria J. Cree   |  |   |                                | 902 Monkton Rd. Monkton, Md. 21111  |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)  |                                | 20c. LOCATION — City or Town, State   |  |  |  |   |  |  |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                 |  | Dulaney Valley Mem.Gdns.9/29/90   |                                | Timonium, Md.   |  |  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |   |                                | 22. NAME AND ADDRESS OF FACILITY  |  |  |  |   |  |  |  |
|   |  |   |                                | Ruck Towson Funeral Home, Inc.<br>1050 York Rd., Towson, Md. 21204  |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |                                |   |  |  |  | Approximate Interval Between Onset and Death  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |   |                                |   |  |  |  |   |  |  |  |
| a. ASPIRATION<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |                                |   |  |  |  |   |  |  |  |
| b. METASTATIC LUNG CANCER<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |                                |   |  |  |  |   |  |  |  |
| c.<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |                                |   |  |  |  |   |  |  |  |
| d.<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |                                |   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
|   |  |   |                                |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |                                | 26. PLACE OF DEATH (Check only one)   |  |  |  |   |  |  |  |
|   |  |   |                                | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH   |  |   |                                | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY                            |  | 28c. INJURY AT WORK?  |  | 28d. DESCRIBE HOW INJURY OCCURED         |  |
| 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  |   |                                |   |  | M  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
|   |  |   |                                | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
|   |  |   |                                |   |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)   |  |   |                                | 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |  |  |   |  |  |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |                                |   |  |  |  |   |  |  |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |                                |   |  |  |  |   |  |  |  |
|   |  |   |                                | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month/Day/Year)              |  |   |  |  |  |
|   |  |   |                                | D28594  |  | 9/26/90  |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |   |                                |   |  |  |  |   |  |  |  |
| Ruth Kauton M.D. G.B.M.C.   |  |   |                                |   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)   |  |   |                                | 32. REGISTRAR'S SIGNATURE   |  |  |  |   |  |  |  |
| OCT 01 1990   |  |   |                                |   |  |  |  |   |  |  |  |



90-5281

ITEMS: 23 thru 28f per ME  
G-668 10-17-90 cm

90 26753

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HARVEY SIDNEY DUFFY, Jr.</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>22</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>1:56 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-46-5183</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>41</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>6-26-49</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Railroad Tracks/Lafayette Avenue</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Laurel</b>  |  | 9c. COUNTY OF DEATH<br><b>Prince George's</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Prince George</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Laurel</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>8410 Spruce Hill Drive</b>   |  |  |  |
| 10f. ZIP CODE<br><b>20707</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Vietnam</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>10</b> Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Painter</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Really Painting Co.</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Harvey Sidney Duffey, Sr.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ruth Virginia Mise</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Harvey Sidney Duffey, Sr.</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>129 Irving Street Laurel, Md 20707</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Baltimore-Washington Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Laurel, Maryland</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Fleck Funeral Home, Inc.<br/>7601 Sandy Spring Road Laurel, Md 20707</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. MULTIPLE INJURIES</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Scene</b>   |  | 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>9-22-90</b>  |  | 28b. TIME OF INJURY<br><b>1:45am</b>   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>SUBJECT WAS STRUCK BY TRAIN</b>  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>RAILROAD TRACKS</b>  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>LAFAYETTE AVENUE LAUREL, MARYLAND</b> |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |  |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-22-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Donald G. Wright, M.D., Deputy Chief 111 Penn Street, Baltimore, MD 21201 vl</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

IVA

Handwritten text, possibly a signature or date, located in the center of the page.

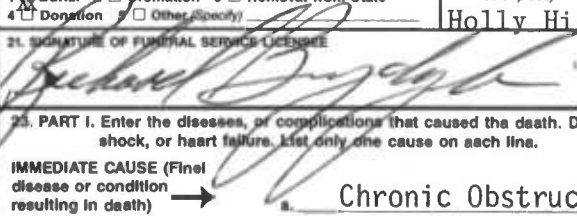
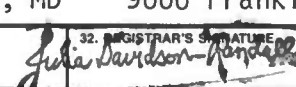


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. DECEDENT'S NAME (First, Middle, Last)  |  |  |                                | 2. DATE OF DEATH<br>MONTH DAY YEAR   |  |  |  | 3. TIME OF DEATH  |  |
|---|--|--|--------------------------------|--|--|--|--|---|--|
| Ruth Louise DAISEY  |  |  |                                | September 29, 1990   |  |  |  | 3:45 A M  |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX   | 6. AGE (In yrs. last birthday) | 7. DATE OF BIRTH<br>(Month, Day, Year)   |  | 8. BIRTHPLACE (State or Foreign Country)                                     |  |   |  |
| 387 24 2976   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                 | 60 YRS.                        | March 12, 1930   |  | Wisconsin  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |  |                                | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |  |  | 9c. COUNTY OF DEATH   |  |
| Franklin Square Hospital  |  |  |                                | Rossville 21237  |  |  |  | Baltimore County  |  |
| 10a. STATE  |  |  |                                | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION  |  | 10d. INSIDE CITY LIMITS?  |  |
| Maryland  |  |  |                                | Baltimore  |  | Middle River   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER  |  |  |                                | 10f. ZIP CODE  |  | 10g. CITIZEN OF WHAT COUNTRY?  |  |   |  |
| 1300 Windlass Road  |  |  |                                | 21220  |  | USA  |  |   |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |                                | 13. WAS DECEDENT OF HISPANIC ORIGIN?   |  | 14. RACE — American Indian, Black, White, etc.                               |  |   |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |                                | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>Specify:  |  | Specify: White   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)  |  |  |                                | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |  |
| Elementary/Secondary (0-12) College (1-4 or 8+)   |  |  |                                | Housewife  |  | Home   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |  |                                | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |  |  |   |  |
| Arthur Robillard  |  |  |                                | Dreda Burbey   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |  |                                | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |  |  |   |  |
| Donna Daisey  |  |  |                                | RD 3 Box 342 Stewartstown, Pennsylvania 17363  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)                               |                                | 20c. LOCATION — City or Town, State  |  |  |  |   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | Holly Hill Memorial Gardens  |                                | Baltimore County Maryland  |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |  |                                | 22. NAME AND ADDRESS OF FACILITY   |  |  |  |   |  |
|   |  |  |                                | Bruzdinski Funeral Home P.A.<br>1407 Old Eastern Ave Baltimore Maryland 21221  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |                                |  |  |  |  | Approximate Interval Between Onset and Death  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → Chronic Obstructive Lung Disease  |  |  |                                |  |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |                                |  |  |  |  |   |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |                                |  |  |  |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |                                |  |  |  |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |                                |  |  |  |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |                                |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |                                |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|   |  |  |                                |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |                                | 26. PLACE OF DEATH (Check only one)  |  |  |  |   |  |
|   |  |  |                                | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH   |  |  |                                | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY  |  | 28c. INJURY AT WORK?  |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |                                |  |  | M  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|   |  |  |                                | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
|   |  |  |                                |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |   |  |
| 29a. CERTIFIER (Check only one)   |  |  |                                | 29c. LICENSE NUMBER  |  |  |  |   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |                                | N/A  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |  |                                | 29d. DATE SIGNED (Month, Day, Year)  |  |  |  |   |  |
| Nada Kiwan  |  |  |                                | 9/29/90  |  |  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |                                |  |  |  |  |   |  |
| Nada Kiwan, MD 9000 Franklin Square Drive   |  |  |                                | Baltimore, MD 21237  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)   |  |  |                                | 32. REGISTRAR'S SIGNATURE  |  |  |  |   |  |
| OCT 01 1990   |  |  |                                |   |  |  |  |   |  |

Donna Daisy

X

Holly Hill

Brudzinski

Chronic Obstructive Lung Disease

90 26755

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EDWARD C DOBBS EDWARD C. DOBBS</b>   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>29</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH <b>3:40 a</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215243530</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.  |  |
| 7a. FACILITY NAME (If not institution, give street and number)<br><b>CHURCH HOSPITAL CORPORATION</b>  |  | 7b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 7c. COUNTY OF DEATH<br><b>---</b>   |  |
| 8a. RESIDENCE OF DECEDENT<br>10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>---</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>716 HUNTING PLACE</b>  |  | 10f. ZIP CODE<br><b>21229</b>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>   |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>DENTIST</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>DENTISTRY</b>  |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>SCOTT E. DOBBS</b>  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY LeFEBVRE</b>   |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>SALLY DOBBS</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>716 HUNTING PLACE BALTIMORE, MD 21229</b>   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>WOODLAWN CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>WOODLAWN, MD</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy M Witzke</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY M &amp; RUSSELL C WITZKE FUNERAL HOME<br/>1630 EDMONDSON AVE CATONSVILLE, MD 21228</b>   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>STROKE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>R. Hajj</i>   |  | 29c. LICENSE NUMBER <b>D39109</b>   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>9/29/90</b>   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>R. HAJJ CHURCH HOSPITAL BALTIMORE, MD. 21231</b>  |  | 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26756

|   |  |  |  |   |   |  |   |  |   |  |
|---|--|--|--|---|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>John J EMKEY  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>September 27, 1990  |   | 3. TIME OF DEATH<br>11:30 PM   |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>213-01-6853- A   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>85 YRS.   |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>June 16, 1905                              |   | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>FRANKLIN SQUARE HOSPITAL  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |   |  | 9c. COUNTY OF DEATH<br>Baltimore  |  |   |  |
| 10a. STATE<br>MARYLAND  |  | 10b. COUNTY<br>-- -- --  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br>3113 BRENDAN AVE.   |  |  |  | 10f. ZIP CODE<br>21213  |   | 10g. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) NA<br>College (1-4 or 5+) NA  |  | 18a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>MECHANIC  |  |   | 18b. KIND OF BUSINESS/INDUSTRY<br>MARTIN MERITTA      |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOHN EMKEY   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MARTHA KAY   |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>MARIE GRUPP (DAUGHTER)  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3113 BRENDAN AVE., BALTIMORE, MD. 21213  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>GREEN MOUNT CEMETERY   |  |   | 20c. LOCATION — City or Town, State<br>BALTIMORE, MD. |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>SCHIMUNEK FUNERAL HOMES, INC.<br>3331 BREHMS LANE, BALTIMORE, MD. 21213   |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Metastatic Lung Cancer<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. Acute Pancreatitis<br>c. Acute Renal Failure<br>d. |  |  |  |   |   |  | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Chronic Obstructive Pulmonary Disease   |  |  |  |   |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED                    |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Matthew W. MacCumber M.D., Ph.D.   |  |  |  |   |   | 29c. LICENSE NUMBER  |   | 29d. DATE SIGNED (Month, Day, Year)<br>9/27/90       |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Matthew MacCumber, M.D. 9000 Franklin Square Dr., Balto., 21237  |  |  |  |   |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 01 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |   |  |   |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |  |  |
|--|--|--|--|---|--|---|--|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MARY S. EVANGELINOS  |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>SEPTEMBER 27, 1990  |  |   |  | 3. TIME OF DEATH<br>7:00P M   |  |  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>234 10 0401   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>81 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Dec. 17, 1908  |  | 8. BIRTHPLACE (State or Foreign Country)<br>West Virginia   |  |   |  |  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  |   |  | 9c. COUNTY OF DEATH<br>BALTIMORE CITY   |  |  |  |  |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>n/a   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |  |  |  |  |
| 10e. STREET AND NUMBER<br>5501 Bowleys Lane  |  |  |  | 10f. ZIP CODE<br>21206  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |  |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |  |   |  |  |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>11   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Home  |  |   |  |   |  |   |  |  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Edward Sestina  |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Veronica Kichak  |  |   |  |   |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Constantine Evangelinos (son)  |  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same as 10 |  |   |  |   |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Elk View Masonic Cemetery  |  |   |  | 20c. LOCATION — City or Town, State<br>Clarksburg, WV   |  |   |  |   |  |  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>David H. H. H.  |  |  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Capitol Funeral Service<br>Falls Church, VA                             |  |   |  |   |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Sepsis<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Aspiration Pneumonia<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death<br>5 days<br>5 days  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Failure to Thrive  |  |  |  |   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |   |  |  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO             |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |   |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Craig Basson  |  |  |  |   |  | 29c. LICENSE NUMBER<br>J 1928   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/25/90  |  |   |  |  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>CRAIG BASSON, JOHNS HOSPITAL HOSPITAL, BALTIMORE, MD 21210  |  |  |  |   |  |   |  |   |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 01 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |   |  |   |  |   |  |  |  |  |  |

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..

... ..



90 26758

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DENISE A. FERGUSON</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>30</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>6:30 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>225-98-7856</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>33</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>7 13 57</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Baltimore</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Harbor Hospital Center</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  |
| 9c. COUNTY OF DEATH  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>448 S. CHAPELGATE LANE</b>  |  |  |  | 10f. ZIP CODE<br><b>21229</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Special Education</b><br>College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN E. FERGUSON, SR.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>DOLORES M. FERGUSON (nee WEBSTER)</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DOLORES FERGUSON</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>448 S. CHAPELGATE LANE</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>LONDON PARK CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Dawn Z. Fisher</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HUBBARD FUNERAL HOME INC.<br/>4107 WILKENS AVENUE, BALTIMORE, MD 21229</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hodgkin's Lymphoma</b><br>Due to (OR AS A CONSEQUENCE OF):<br>a. _____<br>b. _____<br>c. _____<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. _____<br>b. _____<br>c. _____<br>d. _____ |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
|  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dawn Z. Fisher H/O</b>   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-30-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CLAUDIO ZAWITKOWSKI HARBOR HOSPITAL CTR. 3001 S. HANOVER ST. BALTIMORE, MD 21230</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEM:1 per FH G-668  
10-2-90 cm

90 26759

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |
|---|--|--|--|--|--|--|--|---|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>REEDIS JOSEPHINE GRUBB-KING</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>28</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>7:4 A M</b>                           |  |   |  |   |  |  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>234-44-8556</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>MAY 15 1919</b> |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>W. VA.</b>   |  |   |  |  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>FRANCIS SCOTT KEY MED. CENTER</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>---</b>   |  |   |  |  |  |  |  |
| 10a. STATE<br><b>MD.</b>  |  |  |  | 10b. COUNTY<br><b>---</b>  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |  |  |
| 10e. STREET AND NUMBER<br><b>5114 WRIGHT AVENUE</b>   |  |  |  | 10f. ZIP CODE<br><b>21205</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                            |  |   |  |  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>N/A</b> College (1-4 or 5+) <b>N/A</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>PACKER</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>GLASS CO.</b>  |  |   |  |  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>LACY MILES</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SAXTON SIMPKINS</b>  |  |  |  |   |  |   |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARY POSTICK (DGHT)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1402 GEORGIA AVE., SEVERN, MD. 21144</b>   |  |  |  |   |  |   |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GARDENS OF FAITH CEMETERY</b>   |  |  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD.</b>  |  |   |  |  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SCHIMUNEK FUNERAL HOME INC.<br/>3331 Brehms Lane, Baltimore, Md. 21213</b>  |  |  |  |   |  |   |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>End Stage Renal Disease - Uremia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>Chronic Congestive Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>Diabetes Mellitus</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>Anoxic Brain Injury</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>Diabetes Mellitus</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>Anoxic Brain Injury</b><br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b><br><b>Anoxic Brain Injury</b>  |  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |  |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>                              |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                      |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |  |  |
|   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                          |  |   |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  |  |  |  |  | 29c. LICENSE NUMBER<br><b>640394</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/28/90</b>   |  |  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Stephen D. Ryan, M.D.</b>   |  |  |  |  |  |  |  |   |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |   |  |   |  |  |  |  |  |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL, DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



90 26760

FOR STATE REGISTRAR JOSEPH ARTHUR  
**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH** REG. NO.

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Joseph ARTHUR Giacalone</i>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>9 25 90</i>  |  | 3. TIME OF DEATH<br><i>7:40 P.M.</i>  |   |
| 4. SOCIAL SECURITY NUMBER<br><i>067-09-7691</i>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>91</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>OCT. 6, 1898</i>                                   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>3352 CHISWICK CT.</i>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>SILVER SPRING</i>   |  | 9c. COUNTY OF DEATH<br><i>MONTGOMERY</i>  |   |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |   |
| 10a. STATE<br><i>MD.</i>   |  | 10b. COUNTY<br><i>MONTGOMERY</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>SILVER SPRING</i>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><i>3352 CHISWICK CT. APT. 2G</i>   |  |   |  | 10f. ZIP CODE<br><i>20906</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>WHITE</i>                      |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>6</i> College (1-4 or 5+) <i>0</i>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>PRINTER</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>U.S. GOVERNMENT<br/>BUR. OF ENGRAVING</i>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>LOUIS GIACALONE</i>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>JOSEPHINE CAMPIANCO</i>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>EVELYN BREE</i>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>4100 HAYWOOD RD. HORSESHOE, N.C. 28742</i>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>LAYTONSVILLE CEMETERY</i>  |  | 20c. LOCATION — City or Town, State<br><i>LAYTONSVILLE, MD.</i>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Muriel H. Barber</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>MURIEL H. BARBER FUNERAL HOME<br/>21525 LAYTONSVILLE RD. LAYTONSVILLE, MD. 20882</i>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   |   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <i>metastatic cancer - unknown primary - prob colon</i>  |  |   |  |   | Approximate interval between Onset and Death<br><i>6 months</i> |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. <i>Respiratory insufficiency as lung metz</i>  |  |   |  |   | <i>30 days</i>  |
|  |  | c. <i>Anemia 20 Ca</i>  |  |   |  |   | <i>6 months</i>   |
|  |  | d.  |  |   |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>HTBP</i>  |  |   |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |   |   |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Arthur Anderson MD</i>   |  |   |  | 29c. LICENSE NUMBER<br><i>D18726</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9/25/90</i>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>18111 Prince Philip Dr Chevy, MD 20832</i>   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><i>9/28/1990</i>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26761

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>William J. Greenborn</u>  |  |  |  | 2. DATE OF DEATH<br>MONTH <u>9</u> DAY <u>28</u> YEAR <u>90</u>   |  | 3. TIME OF DEATH<br><u>03:50</u> <u>A</u> M   |   |
| 4. SOCIAL SECURITY NUMBER<br><u>212-16-5663</u>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><u>68</u> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><u>11/13/21</u>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><u>Maryland</u>   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>St. Agnes Hospital</u>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Baltimore</u>   |  | 9c. COUNTY OF DEATH<br><u>Baltimore</u>   |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |
| 10a. STATE<br><u>Maryland</u>  |  | 10b. COUNTY<br><u>Baltimore</u>  |  | 10c. CITY, TOWN OR LOCATION<br><u>Arbutus</u>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><u>1243 Sulphur Spring Road</u>  |  |  |  | 10f. ZIP CODE<br><u>21227</u>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE YEAR OR DATES<br><u>WW II</u> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>white</u>                             |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (8-12) <u>College (1-4 or 6+)</u>  |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><u>sales</u>                             |  | 15b. KIND OF BUSINESS/INDUSTRY<br><u>retail</u>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>William Greenborn</u>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Anna C. Ruff</u>  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Marie Krietz</u>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>8618 Ellen Ct. Parkville, Maryland</u>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>St. Augustines Cemetery</u>   |  | 20c. LOCATION — City or Town, State<br><u>Elkridge, Maryland</u>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>Ambrose Funeral Home, Inc.</u><br><u>1328 Sulphur Spring Road, Arbutus, Md. 21227</u>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Cardio pulmonary arrest. ? 1-2 M</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Renal fail. hyperkalemia</u><br><u>? lung Cancer</u>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><u>M</u>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><u>039357</u>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>9/28/90</u>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>RABIE ZALZAL — St. Agnes Hospital</u>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><u>OCT 10 1990</u>  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26762

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOHN Thomas HEBRON</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>28</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>3 15 PM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-22-4989</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>98</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>07/25/1892</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>LIBERTY MEDICAL CENTER</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>  |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>Maryland</b>  |  |   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br><b>1701 EULAW PLACE Apt 206</b>  |  | 10f. ZIP CODE<br><b>21217</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)                           |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>UNKNOWN</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>UNKNOWN</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Minnie Hebron</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1701 EULAW PLACE Apt 206 BALTO, MD 21217</b>                               |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ARADUS Mem. Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTO. CO. MD</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph J. Russ</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph J. Russ Funeral Home<br/>2222 W. North Ave. BALTO, MD 21216</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>METASTATIC PROSTATIC CARCINOMA</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><b>ARTERIOSCLEROTIC HEART DISEASE</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |  |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DECUBITUS ULCER</b><br><b>ANEMIA</b><br><b>PAGEY'S DISEASE</b>  |  |   |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature] M.D.</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D 23300</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9.28.90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SUDHIR D. PATEL 2600 LIBERTY RD. BALTO. 21215</b>  |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached to the certificate for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mary Susanne Howe   |  |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 25 YEAR 90  |  | 3. TIME OF DEATH<br>2:10PM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>215-01-9500  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>88 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Aug. 4 1902                                   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>MD.   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>4604 Moravia Road   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City                                |  |
| 9c. COUNTY OF DEATH<br>----   |  |  |  | 10a. STATE<br>MD.   |  |  |  |
| 10b. COUNTY<br>-----  |  |  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  |  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br>4604 MORAVIA RD.  |  |  |  |
| 10f. ZIP CODE<br>21206  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                     |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) N/A<br>College (1-4 or 5+) N/A  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>CLERK   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>DEPT. STORE   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOHN JACOB SCHADEGG  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>BRIDGET GILOOLEY   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>DORIS MARIE CARRE (DGHTR)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4604 MORAVIA RD., BALTIMORE, MD. 21206   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>NEW CATHEDRAL CEMETERY   |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MD.   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Harvey W. Bain   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>SCHIMUNEK FUNERAL HOME INC.<br>3331 Brehms Lane, Baltimore, Md. 21213   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>INQUIRY<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Frank Peretti  |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-26-90                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>FRANK PERETTI, MD 111 Penn Street, Baltimore, MD 21201   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 01 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26764

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>RUFUS H HARLEY   |  |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 27 YEAR 90  |  | 3. TIME OF DEATH<br>8:00 P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>167-05-6947   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>75 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>9/5/1915   |  |
| 8a. FACILITY NAME (If not institution, give street and number)<br>UNIV. OF MD. HOSP.   |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  | 8c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT  |  |  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10a. STATE<br>MD   |  | 10b. COUNTY  |  | 10e. STREET AND NUMBER<br>5226 ST CHARLES AVE   |  | 10f. ZIP CODE<br>21215  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: Black   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Lab. Tech  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>U.S. Govt.  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Henry Harley  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Louisa Harley  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Othelia Judge  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5226 St. Charles Avenue Balto., Md. 21215  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Western Star   |  | 20c. LOCATION — City or Town, State<br>Balto., Md.  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James A. Morton</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>James A. Morton & Sons<br>1701 Laurens St. Balto., Md. 21217  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Urosepsis</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death<br>12 days   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Upper Gastrointestinal Bleeding</i>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)  |  |
| 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Jose MA Maisog, MD.</i>  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>► 9-28-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>JOSE MA MAISOG  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 01 1990   |  | 32. REGISTRAR'S SIGNATURE<br><i>Juha Davidson-Randall</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial or cremation form. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26765

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PAUL BENNETT JONES</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>28</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>1040 A M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>167-074631-A</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>July 27 1906</b>                                   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pittsburgh, Pa.</b>   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH   |   |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |   |
| 10a. STATE<br><b>Md</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>5608 Chelwynd Road</b>  |  |  |  | 10f. ZIP CODE<br><b>21227</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b><br><b>12th grade</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Electrical</b>           |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>UNKNOWN</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>UNKNOWN</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Shirley Jones</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5608 Chelwynd Road, Baltimore, MD 21227</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Meadowridge Mem.Pk.Metro Crematory</b>                          |  | 20c. LOCATION — City or Town, State<br><b>Baltimore</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hubbard Funeral Home Inc.</b><br><b>4107 Wilkens Ave., Balto., Md. 21229</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <b>Candida Sepsis - Aspiration Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Immune-deficiency.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>debilitated state.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>Acute Encephalopathy.</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>10 days.</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |   |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> <b>Dr. Oney Luviza, Medical Resident.</b>  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>09-28-90.</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Oney Luviza, 900 Catm St. Balto MD 21229.</b>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>09-28-90</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26766

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |                                |  |   |
|---|--|---|--|---|--------------------------------|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Helen JACOBS</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>26</b> YEAR <b>90</b>   |                                | 3. TIME OF DEATH<br><b>2 P.M.</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>198 07 7048</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>NOV. 18, 1918</b>                   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Brooklyn, NY</b>   |  |   |  |   |                                |  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Arthea Woodland Nursing Home</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring md</b>  |                                | 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |   |
| 10a. STATE<br><b>New York</b>   |  |   |  | 10b. COUNTY<br><b>Queens</b>  |                                | 10c. CITY, TOWN OR LOCATION<br><b>Far Rockaway</b>                               |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |   |                                |  |   |
| 10e. STREET AND NUMBER<br><b>135 Beach 19th Street</b>  |  |   |  | 10f. ZIP CODE<br><b>11961</b>   |                                | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                      |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |                                | 14. RACE — American Indian, Black, White, etc.<br><b>White</b>                   |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Bookkeeper</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Private Business</b>   |                                |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Hyman Lieberman</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rose Eframovitz</b>   |                                |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Gilbert Jacobs</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2836 Mozart Drive Silver Spring, Md. 20904</b>  |                                |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Lebanon Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Adelphi, Md.</b>  |                                |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ives-Pearson Funeral Homes<br/>Falls Church, Va. 22046</b>   |                                |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory insufficiency</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Lung Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |   |  |   |                                |  | Approximate Interval Between Onset and Death<br><b>2 days</b><br><b>6 months</b>                      |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Bone metastases</b>  |  |   |  |   |                                |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |   |                                |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |                                |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |                                | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |                                | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)     |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |                                |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Peter B. Sherer MD</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>21910</b>   |                                | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/27/90</b>                            |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Peter B. Sherer MD 3947 Ferrara Dr. Wheaton, md</b>   |  |   |  |   |                                |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |                                |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-0146  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



6  
90 267671 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PETER JACHEM</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>30</b> YEAR <b>90</b> |  |   |   | 3. TIME OF DEATH<br><b>12:30 p.m.</b> |  |   |   |   |  |   |               |  |               |  |  |  |  |
|--|--|--|--|--|--|---|---|---------------------------------------|--|---|---|---|--|---|---------------|--|---------------|--|--|--|--|
| 4. SOCIAL SECURITY NUMBER<br><b>213-07-8214</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b> |   | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>  |                                       | 7. DATE OF BIRTH (Month, Day, Year)<br><b>07-02-15</b>                     |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>BALTO., MD</b> |   |  |   |               |  |               |  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>CANTON HARBOR NURSING CENTRE</b>  |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE, MARYLAND</b>   |   |                                       |  | 9c. COUNTY OF DEATH<br><b>-</b>   |   |   |  |   |               |  |               |  |  |  |  |
| 10a. STATE<br><b>Maryland</b>  |  |  | 10b. COUNTY<br><b>-</b>  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore, Maryland</b>   |   |                                       |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |   |  |   |               |  |               |  |  |  |  |
| 10e. STREET AND NUMBER<br><b>411 Imla Street</b>   |  |  |  |  |  | 10f. ZIP CODE<br><b>21224</b>   |   |                                       | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                             |   |   |   |  |   |               |  |               |  |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |   |                                       | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |   |   |   |  |   |               |  |               |  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6</b><br>College (1-4 or 5+) <b>0</b>   |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Crane Operator</b>   |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Steel Industry</b>   |   |                                       |  |   |   |   |  |   |               |  |               |  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Stanley Jachem</b>   |  |  |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Caroline Majka</b>  |   |                                       |  |   |   |   |  |   |               |  |               |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Genevieve Jachem</b>  |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>411 Imla Street Balto. Md. 21224</b>  |   |                                       |  |   |   |   |  |   |               |  |               |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Stanislaus Cemetery</b>   |  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>   |   |                                       |  |   |   |   |  |   |               |  |               |  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>George A. Weber</i><br><b>George A. Weber &amp; Sons Inc.</b>  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>George A. Weber &amp; Sons Inc.</b><br><b>705 S. Ann St. Balto. Md. 21231</b>   |  |  |   |   |                                       |  |   |   |   |  |   |               |  |               |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><table border="1"><thead><tr><th>IMMEDIATE CAUSE (Final disease or condition resulting in death)</th><th>Approximate Interval Between Onset and Death</th></tr></thead><tbody><tr><td>a. <b>Pneumonia</b><br/>DUE TO (OR AS A CONSEQUENCE OF):</td><td><b>2 days</b></td></tr><tr><td>b. <b>Stroke</b><br/>DUE TO (OR AS A CONSEQUENCE OF):</td><td><b>1 year</b></td></tr><tr><td>c. <br/>DUE TO (OR AS A CONSEQUENCE OF):</td><td></td></tr><tr><td>d. <br/>DUE TO (OR AS A CONSEQUENCE OF):</td><td></td></tr></tbody></table> |  |  |  |  |  |   |   |                                       |  |   |   | IMMEDIATE CAUSE (Final disease or condition resulting in death) | Approximate Interval Between Onset and Death | a. <b>Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF): | <b>2 days</b> | b. <b>Stroke</b><br>DUE TO (OR AS A CONSEQUENCE OF): | <b>1 year</b> | c.<br>DUE TO (OR AS A CONSEQUENCE OF): |  | d.<br>DUE TO (OR AS A CONSEQUENCE OF): |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death)  | Approximate Interval Between Onset and Death |  |  |  |  |   |   |                                       |  |   |   |   |  |   |               |  |               |  |  |  |  |
| a. <b>Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):  | <b>2 days</b>                                |  |  |  |  |   |   |                                       |  |   |   |   |  |   |               |  |               |  |  |  |  |
| b. <b>Stroke</b><br>DUE TO (OR AS A CONSEQUENCE OF):   | <b>1 year</b>                                |  |  |  |  |   |   |                                       |  |   |   |   |  |   |               |  |               |  |  |  |  |
| c.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |   |   |                                       |  |   |   |   |  |   |               |  |               |  |  |  |  |
| d.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |   |   |                                       |  |   |   |   |  |   |               |  |               |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Colon Cancer</b>  |  |  |  |  |  |   |   |                                       |  |   |   |   |  |   |               |  |               |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |                                       |  |   |   |   |  |   |               |  |               |  |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M                         |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                       | 28d. DESCRIBE HOW INJURY OCCURRED  |   |   |   |  |   |               |  |               |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>James F. Carow MD</b>   |   |                                       | 29c. LICENSE NUMBER<br><b>034915</b>                                       |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/30/90</b>         |   |  |   |               |  |               |  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>James F. Carow, MD 2920 O'Donnell St, Baltimore, MD 21224</b>  |  |  |  |  |  |   |   |                                       |  |   |   |   |  |   |               |  |               |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |   |   |                                       |  |   |   |   |  |   |               |  |               |  |  |  |  |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1877

1877

1877

1877

1877

1877

1877

1877

1877

1877

1877

1877

1877

1877

1877

1877

1877

1877

1877

1877

1877

1877

1877

1877

1877

1877

1877

1877

1877

90 26768

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |   |   |  |   |  |
|--|--|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>WILLIAM A. JOHNSON SR.   |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>SEPT. 28, 1990  |  | 3. TIME OF DEATH<br>4:45 A M  |  |
| 4. SOCIAL SECURITY NUMBER<br>214-18-9411   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>79 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>APRIL 17, 1911  | 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>3020 PATUXENT OVERLOOK COURT   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>ELLCOTT CITY   |  | 9c. COUNTY OF DEATH<br>HOWARD   |  |
| RESIDENCE OF DECEDENT  |  |  |   |   |  |   |  |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>HOWARD  |   | 10c. CITY, TOWN OR LOCATION<br>ELLCOTT CITY   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>3020 PATUXENT OVERLOOK COURT   |  |  |   | 10f. ZIP CODE<br>21043  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>6   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>OPERATING ENGINEER  |   | 16b. KIND OF BUSINESS/INDUSTRY<br>CONSTRUCTION  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOHN T. JOHNSON   |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ELLA NEIGHOFF  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>THERESA JOHNSON  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3020 PATUXENT OVERLOOK COURT, ELLCOTT CITY, MD. 21043  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MEADOWRIDGE MEMORIAL PARK  |   | 20c. LOCATION — City or Town, State<br>DORSEY, MARYLAND   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Sinda M. Witzke</i>  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES<br>1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Respiratory failure</i><br>ONE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. <i>Chronic Obstructive Pulmonary Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death |  |  |   |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Gastrointestinal bleeding</i>   |  |  |   |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |   |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |   |   |  |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY M  |   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dr. Dorian St. Martin</i>  |  |  |   | 29c. LICENSE NUMBER<br>D28236   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/28/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DR. DORIAN ST. MARTIN 5411 OLD FREDERICK ROAD SUITE # 7, BALTIMORE, MD. 21229   |  |  |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 01 1990   |  |  |   | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

13602 02

Handwritten scribbles and marks at the bottom left corner.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

**BALTIMORE, MARYLAND 21203-3146**

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

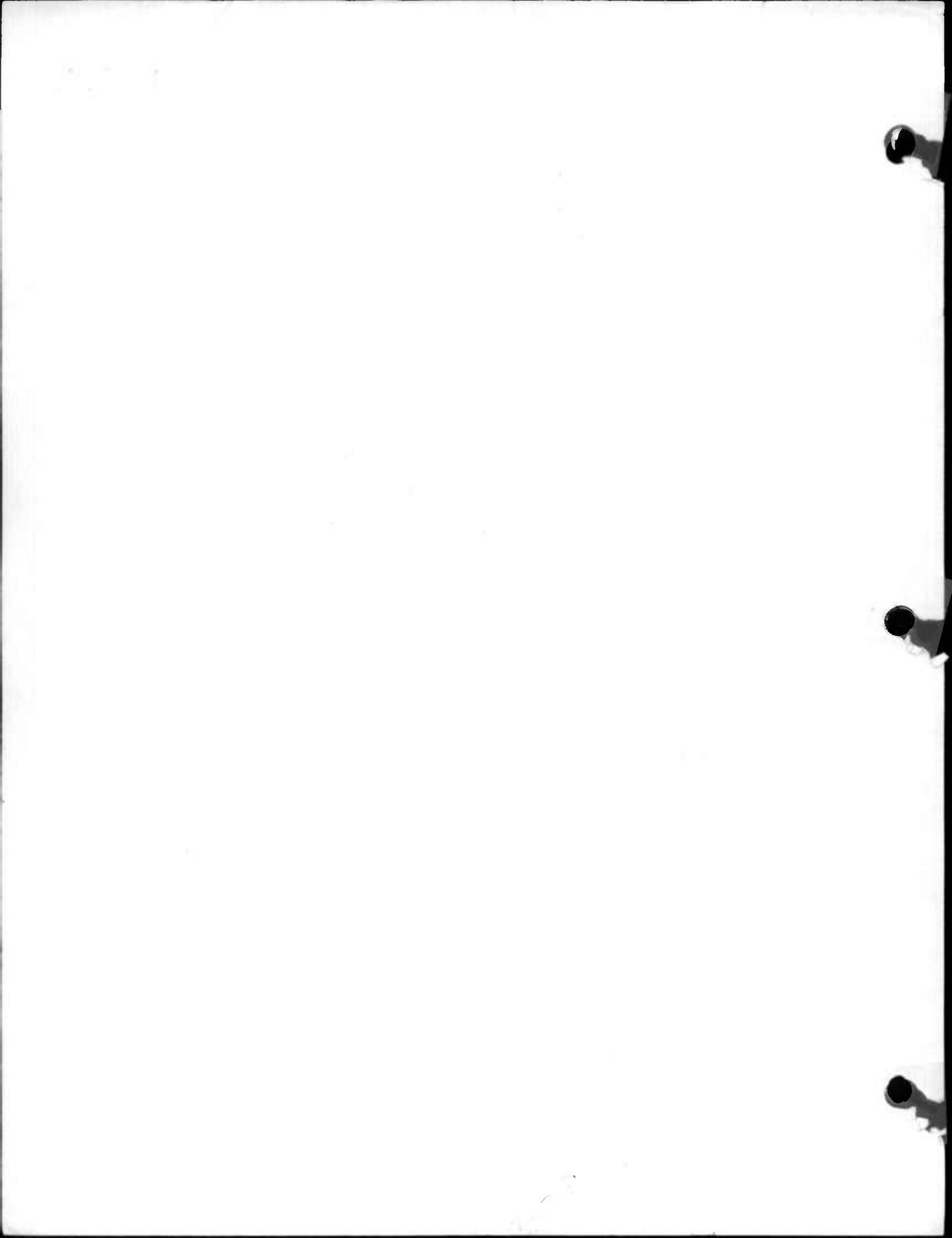
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|  |                           |  |  |   |
|--|---------------------------|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>STella m. Korecky</b>   |                           | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>30</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>6p</b>   |
| 4. SOCIAL SECURITY NUMBER<br><b>212-74-1684</b>  | 5. SEX<br><b>1 M 2 F</b>  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____ | IF UNDER 24 HRS.<br>HOURS _____ MIN. _____  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>OCT. 13, 1907</b>   |                           | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD.</b>   |  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ST. JOSEPH Hospital</b>   |                           | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>   |
| RESIDENCE OF DECEDENT  |                           |  |  |   |
| 10a. STATE<br><b>MD</b>  | 10b. COUNTY<br><b>---</b> | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  | 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>   |
| 10e. STREET AND NUMBER<br><b>3414 Dudley Avenue</b>  |                           | 10f. ZIP CODE<br><b>21213</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |
| 11. MARITAL STATUS<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>  |                           | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b><br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 NO</b> Specify: |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>  |                           |  |  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)   |                           | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY  |
| Elementary/Secondary (0-12)<br><b>NA</b>   |                           | College (1-4 or 5+)<br><b>NA</b>   |  | <b>HOMEMAKER</b>  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOSEPH RUBY</b>  |                           | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>BARBARA PORKONY</b>  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>RONALD J. KORECKY (SON)</b>   |                           | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5522 McCORMICK AVE., BALTIMORE, MD. 21206</b>      |  |   |
| 20a. METHOD OF DISPOSITION<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify)</b>  |                           | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BALTIMORE NATIONAL CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD.</b>  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |                           | 22. NAME AND ADDRESS OF FACILITY<br><b>SCHIMUNEK FUNERAL HOMES, INC.<br/>3331 BREHMS LANE, BALTIMORE, MD. 21213</b>                                    |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARCINOMATOSIS</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>METASTATIC COLON CA</b><br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 NO</b><br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b> |                           |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 NO</b>  |                           | 26. PLACE OF OATH (Check only one)<br>HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b><br>OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |   |
| 27. MANNER OF DEATH<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>  |                           | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |
| 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>  |                           | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |                           | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. CERTIFIER<br>(Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>   |                           |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>- SURGICAL HOUSE OFFICER  |                           | 29c. LICENSE NUMBER<br><b>D-24710</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-30-90</b>   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ARMANDO A REAL, MD ST JOSEPH HOSP 7620 YORK Rd. Towson MD 21204</b>  |                           |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 30 1990</b>  |                           | 32. REGISTRAR'S SIGNATURE<br>  |  |   |





90-5468

90 26770

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |   |
|--|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Michael Patrick Kearney  |  |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 28 YEAR 90   |  | 3. TIME OF DEATH<br>11:25 P M  |   |
| 4. SOCIAL SECURITY NUMBER<br>200-60-0940   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>27 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Dec. 21, 1962  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Pennsylvania   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Prince George's General Hospital   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Cheverly  |   |
| 9c. COUNTY OF DEATH<br>Prince George's   |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Calvert   |   |
| 10c. CITY, TOWN OR LOCATION<br>Solomons  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>P.O. Box 903   |   |
| 10f. ZIP CODE<br>20688   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)<br>5  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Nuclear Engineer  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Energy   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>William Kearney   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Rilla Mansell   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>William Kearney  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>RD 1, Box 7K, Loretto, PA 15940   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>St. Francis Xavier   |  | 20c. LOCATION — City or Town, State<br>Cresson, PA   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>ROBERT C. ALTENBURG FUNERAL HOME, INC.<br>6009 Harford Rd., Baltimore, MD 21214  |  |  |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Transection of Aorta<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  | Approximate interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br>9/28/90   |  | 28b. TIME OF INJURY<br>8:20P M   |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE NOW INJURY OCCURRED<br>driver in auto/auto collision   |  |  |   |
| 28e. PLACE OF INJURY — All home, farm, street, factory, office building, etc. (Specify)<br>roadway   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>Rt. #258 & #2, Tracy's Landing, Anne Arundel Co., Md.  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  | 29c. LICENSE NUMBER<br>OCME  |   |
| 29d. DATE SIGNED (Month, Day, Year)<br>9/30/90   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ann M. Dixon, M.D. 111 Penn St. Baltimore, Md. 21201  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>OCT 01 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a travel permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26771

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>George Koessler</b>  |  |   |  | 2. DATE OF DEATH<br><b>SEP. 27, 1990</b> YEAR   |  | 3. TIME OF DEATH<br><b>M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-03-7902</b>   |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>90</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>02/27/00</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Bavaria</b>  |  |   |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>4417 Leeds Avenue</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Arbutus</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |  |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Arbutus</b>   |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>4417 Leeds Avenue</b>  |  |   |  | 10f. ZIP CODE<br><b>21227</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>N/A</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>cabinet maker</b>  |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>wood</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Bonaventura Koessler</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Cecilia Schudell</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Emily B. Koessler</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4417 Leeds Avenue Arbutus Md 21227</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Dorsey, Maryland</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ambrose Funeral Home<br/>1328 Sulphur Spring Road, Arbutus, Md</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>ASCA</b><br><b>Vent. Failure</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>1</b> <input type="checkbox"/> DUE TO (OR AS A CONSEQUENCE OF):<br><b>2</b> <input type="checkbox"/> DUE TO (OR AS A CONSEQUENCE OF):<br><b>3</b> <input type="checkbox"/> DUE TO (OR AS A CONSEQUENCE OF):<br><b>4</b> <input type="checkbox"/> DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |  | Approximate Interval Between Onset and Death<br><b>1 1/2</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><b>1</b> <input type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide<br><b>6</b> <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO       |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |   |  | 29c. LICENSE NUMBER<br><b>U390</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>11/2/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><b>Raymond M. M...</b>  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 10 1990</b>   |  |   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26772

FOR  
STATE  
REGISTRAR **STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**Hazel Leona McGhee Keene** **CERTIFICATE OF DEATH** REG. NO.

|  |  |  |  |  |                                |  |  |
|--|--|--|--|--|--------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HAZEL KEENE</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>29</b> YEAR <b>90</b>  |                                | 3. TIME OF DEATH<br><b>5:30 A</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>223-46-9491</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS   | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>2/29/17</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Homewood Hospital Center</b>  |                                | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  |
| 9c. COUNTY OF DEATH<br><b>-----</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>  |                                | 10b. COUNTY<br><b>----</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |                                | 10e. STREET AND NUMBER<br><b>1104 West 38th Street</b>   |  |
| 10f. ZIP CODE<br><b>21211</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>4 yrs.</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>  |                                | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Elbert McGhee</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Laura Newberry</b>   |                                |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Barbara Eyrett</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1104 West 38th Street Baltimore, Md. 21211</b>   |                                |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Green Hill Memorial Gardens</b>   |                                | 20c. LOCATION — City or Town, State<br><b>Claypoll Hill, Virginia</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Alan Seitz</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>3818 Roland Ave. Balto, Md. 21211</b><br><b>A. Alan Seitz, Jr. Funeral Home</b>   |                                |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |                                |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASPIRATION PNEUMONIA</b>  |  |  |  |  |                                |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |                                |  |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |  |                                |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |                                |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |                                |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |                                |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>SENILE DEMENTIA</b>   |  |  |  |  |                                |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |                                |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |                                | 28b. TIME OF INJURY<br>M   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |                                |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |                                |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |                                |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Chubach</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>73/905</b>   |                                | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/29/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Mrs. Betty Woreta, Homewood Hosp. Center</b>   |  |  |  |  |                                |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 10 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |                                |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ST. 11 18

90 26773

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>John Joseph Kunkowski</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 24 90</b>   |  | 3. TIME OF DEATH<br><b>1:14 p.m.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-30-1419</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>01/22/27</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Greater Baltimore Medical Center</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |  | 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Cockeysville</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>10315L Malcolm Circle</b>   |  |
| 10f. ZIP CODE<br><b>21030</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WW II</b>   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6 yrs</b><br>College (1-4 or 5+) <b>Corporate Executive</b>  |  |  |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Corporate Executive</b>  |  | 15b. KIND OF BUSINESS/INDUSTRY<br><b>W.R. Grace and Co.</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Dr. Andrew Kunkowski</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Wanda Kedzierski</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Gregg W. Kunkowski</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10315L Malcolm Cir Cockeysville, Md. 21030</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Dulaney Valley 9-27-90</b>   |  | 20c. LOCATION — City or Town, State<br><b>Timonium, Md.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, Md. 21204</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>HYPERTENSIVE ARTERIOSCLEROTIC</b>   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF): <b>C-V DISEASE</b>  |  |  |  |   |  |  |  |
| Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>WHILE DRIVING HIS AUTOMOBILE</b> |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Carlton L. Sexton, M.D.</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D10008</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-25-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Carlton Sexton M.D. 901 N. Howard St.</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26774

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GUSTA LEINWAND</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>25</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>2:30 A.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>030-16-1472</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS.  |  | 7. DATE OF BIRTH<br>MONTH <b>May</b> DAY <b>27</b> YEAR <b>1912</b>                             |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Suburban Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Bethesda</b>  |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Montgomery</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>6121 Montrose Road</b>   |  |  |  | 10f. ZIP CODE<br><b>20852</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>2</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>            |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>own home</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Jacob Rabinowicz</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rachael Kavanoki</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jack Zeller</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11603 Gilsan Street, Silver Spring, MD. 20902</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Temple Emeth Memorial Park</b>                                  |  | 20c. LOCATION — City or Town, State<br><b>West Roxbury, Mass.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Pete Pearson</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ives-Pearson Funeral Homes<br/>Falls Church, Virginia</b>  |  |   |  |
| 23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CARDIOPULMONARY ARREST</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. RIGHT HEMICOLECTOMY</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. LOWER GI BLEED</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 26a. DATE OF INJURY (Month, Day, Year)   |  | 26b. TIME OF INJURY<br><b>M</b>   |  | 26c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|   |  | 26d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 26e. DESCRIBE HOW INJURY OCCURRED   |  | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Marilyn Vermump, M.D. PHYSICIAN</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D35791</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/25/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>HEBREW HOME OF GREATER WASH., ROCKVILLE MD.</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26775

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MYRA I McWILLIAMS</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>28</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>1132 AM</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>220-38-7602</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>49</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>6-29-41</b>   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>BALTO. Md.</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>University Hosp</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>   |   |
| 9c. COUNTY OF DEATH   |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY  |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>710 Kevin Road</b>  |   |
| 10f. ZIP CODE<br><b>21229</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>   |  |  |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Postal Worker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Post office</b>   |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Randolph Washington</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lucretia Finney</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. Winfred McWilliams</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>710 Kevin Rd. Baltimore Md. 21229</b>                                      |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Garrison Forest La. Cem.</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTO. Co. Md.</b>   |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph L. Russ</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph L. Russ Funeral Home<br/>2252 W. North Ave. BALTO. Md. 21216</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrhythmia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>Hypoxia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Cerebral aneurysms</b><br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><b>38min</b><br><b>40min</b>                          |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cerebral aneurysms</b>   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>LEON LIEM MD</b>  |  |  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/28/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>LEON LIEM MD</b>  |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>   |  |  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26776

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ANDREW A MANIK</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>27</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>9:20p</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-01-3679</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug. 29, 1920</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>PENNSYLVANIA</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>HOMEWOOD HOSPITAL</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore, Md.</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |  | 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY<br><b>---</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>3628 KENYON AVE.</b>   |  |
| 10f. ZIP CODE<br><b>21213</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b>  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |   |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>NA</b> College (1-4 or 5+) <b>NA</b>  |  |   |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>ASSEMBLY WORKER</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>AUTOMOBILE COMPANY</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>CHARLES MANIK</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY POPE</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DORIS M. MANIK (WIFE)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3628 KENYON AVE, BALTIMORE, MD. 21213</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>DULANEY VALLEY MEM. GARDENS</b>  |  |   |  |
| 20c. LOCATION — City or Town, State<br><b>TIMONIUM, MARYLAND</b>   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Eugene J. Cantor</i>  |  |   |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>SCHIMUNEK FUNERAL HOMES, INC.<br/>3331 BREHMS LANE, BALTIMORE, MD. 21213</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC LUNG CANCER</b><br><b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br>a. DUE TO (OR AS A CONSEQUENCE OF): <b>CVA</b><br>b. DUE TO (OR AS A CONSEQUENCE OF): <b>Pneumonia</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br><b>M</b>   |  |   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Terance L. Lamb M.D.</i>  |  |   |  |
| 29c. LICENSE NUMBER<br><b>D37203</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-27-90</b>   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>TERANCE L. LAMB HOMEWOOD HOSPITAL, Baltimore, Md. 21043</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rodella</i>  |  |   |  |

Stomach (Lung)

Metastatic Lung Cancer

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) <b>Catherine J. Menton</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9-27-90</b>  |  | 3. TIME OF DEATH<br><b>3:05 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>575 66 8105</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Sept. 13, 1909</b>                                 |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Penna.</b>  |  |   |  |   |  |   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>Holy Cross Hospital</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| 10a. STATE<br><b>PENNA</b>   |  | 10b. COUNTY<br><b>SCHUYLKILL</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Wheaton</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>2611 Blueridge Ave.</b>   |  |   |  | 10f. ZIP CODE<br><b>20902 17946</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br><b>White</b>                                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Registered Nurse</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U. S. Army</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>John Joyee</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Rusk</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Leta K. Menton (daughter)</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as 10 2611 BLUE RIDGE AVE WHEATON, MD 20902</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>St. Joseph's Cenetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Ashland, PA</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>David L. Sanders</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Capitol Funeral Service<br/>Falls Church, VA</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ruptured aortic aneurysm.</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John Tander MD</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>108546</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-27-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John Tander 8218 WISCONSIN ave Bethesda</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

U.S. 100

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10

1000 10 10 10 10 10



90 26778

FOR STATE REGISTRAR ELIZABETH MULLINEAUX STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
**CERTIFICATE OF DEATH** REG. NO.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Elizabeth</i> VIRGINIA <i>Mullineaux</i>  |  | 2. DATE OF DEATH<br>MONTH <i>09</i> DAY <i>26</i> YEAR <i>90</i>   |  | 3. TIME OF DEATH<br><i>1:00 p.m.</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>214-08-1441</i>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>68</i> YRS.  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>OCT. 25, 1921</i>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>MD.</i>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>PLEASANT VIEW NURSING HOME</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>MT. AIRY</i>   |  | 9c. COUNTY OF DEATH<br><i>CARROLL</i>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |
| 10a. STATE<br><i>MD.</i>   |  | 10b. COUNTY<br><i>CARROLL</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>MT. AIRY</i>  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |
| 10e. STREET AND NUMBER<br><i>101 OLD NATIONAL PIKE</i>   |  | 10f. ZIP CODE<br><i>21771</i>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>WHITE</i>  |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>8</i> College (14 or 5+) <i>0</i>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Homemaker</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Home</i>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>CLAUDE F. MULLINEAUX</i>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>AGNES MYRTLE HARRISON</i>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>JOHN F. MULLINEAUX</i>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>510 ANDERSON AVE. ROCKVILLE, MD. 20850</i>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>METROPOLITAN CREMATORY</i>  |  | 20c. LOCATION — City or Town, State<br><i>ALEXANDRIA, VA.</i>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Muriel H. Barber</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>MURIEL H. BARBER FUNERAL HOME<br/>21525 LAYTONSVILLE RD. LAYTONSVILLE, MD. 20882</i>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | a. <i>Acute Respiratory Failure</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. <i>Pneumonia</i><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |
|  |  | c. <i>DO</i><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |
|  |  | d.   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Seizures, Retarded, Schizophrenia</i>   |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>   |  |
|  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Melvin Kordon</i>  |  | 29c. LICENSE NUMBER<br><i>D06588</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9/26/90</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>DR. MELVIN KORDON COLUMBIA, MD.</i>  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>OCT 01 1990</i>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26779

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|   |  |  |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>VIOLET H. MILLER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>29</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>11-30 A.M.</b>   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217 64 3235</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>06/ 5/13</b>   |  |   |  |
| 8. FACILITY NAME (If not institution, give street and number)<br><b>Fallston General Hospital</b>   |  |  |  | 9. CITY, TOWN OR LOCATION OF DEATH<br><b>Fallston,</b>  |  | 10. COUNTY OF DEATH<br><b>Harford</b>   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore City</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><b>XX</b> YES 2 <input type="checkbox"/> NO                                   |  |   |  |
| 10e. STREET AND NUMBER<br><b>2609 Hampden Avenue</b>  |  |  |  | 10f. ZIP CODE<br><b>21211</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                                |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 8+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>LeRoy Lowman</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Hughes</b>   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Vernon Miller, Jr.</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1503 Kittering Court Bel Air, Maryland 21014</b>  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Woodlawn, Maryland</b>  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>By Lynn Burger Henss</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Burgee-Henss Funeral Home<br/>3631 Falls Road, Baltimore, Md 21211</b>   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Perforated Duodenal Ulcer</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><div style="display: flex; justify-content: space-between;"> <div>           a. DUE TO (OR AS A CONSEQUENCE OF):<br/> <b>Peritonitis - Septicemia - Renal failure</b><br/>           b. DUE TO (OR AS A CONSEQUENCE OF):<br/> <b>Cardio - Respiratory failure</b><br/>           c. DUE TO (OR AS A CONSEQUENCE OF):<br/> <b>Hypertension</b><br/>           d.         </div> <div>           Approximate Interval Between Onset and Death<br/> <b>9/15/90</b><br/> <b>9/15/90</b><br/> <b>9/15/90</b><br/> <b>8-Years</b> </div> </div> |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypoproteinemia - Hypothermia</b><br><b>Recurrent Perforation of Duodenal Ulcer</b>  |  |  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  |   |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                              |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dr. Burush M.D.</b>   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-29-90</b>   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><b>ABDUL G. QURESHI, M.D. P.O. Box 16549, 501-DOLPHIN ST. BALT. 21217 MD</b>  |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |   |  |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

100-100

90 26780

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Reginald McCullough</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>9</i> DAY <i>25</i> YEAR <i>90</i>   |  | 3. TIME OF DEATH<br><i>4:05 PM</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>212-58-2116</i>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>37</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>10-1-52</i>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><i>US</i>   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><i>Francis Scott Key Med. Ctr.</i>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore MD</i>  |  | 9c. COUNTY OF DEATH<br><i>Balt. City</i>  |  |
| 10a. STATE<br><i>MD</i>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><i>Baltimore</i>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>912 N. Castle St.</i>  |  | 10f. ZIP CODE<br><i>21205</i>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>US</i>  |  |   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>Vietnam</i>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>Black</i>                         |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>truck driver</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Otis McCullough</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Hattie Dora Thompson</i>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Hattie McCullough</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>912 N. Castle St., Balto., MD.</i>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Maryland Natl. Mem. Park</i>  |  | 20c. LOCATION — City or Town, State<br><i>Laurel, MD</i>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles S. Brown</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Joseph H. Brown F.H. P.O. Box 4433<br/>Balto., MD. 21223</i>  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hyperkalemia</i><br>DUE TO (OR AS A CONSEQUENCE OF): <i>Alcoholism</i><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <i>Renal Failure</i><br>DUE TO (OR AS A CONSEQUENCE OF): <i>Liver failure</i><br><i>Hepato-Renal Syndrome</i><br>DUE TO (OR AS A CONSEQUENCE OF): <i>Alcoholic Hepatic Encephalopathy</i> |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><i>3 d.</i><br><br><br><br><br><br><br><br><br><br><i>12 d</i>                                     |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
|   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>James</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>D24334</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9/26/90</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Lidia Palcan MD Francis Scott Key Med Ctr. 4940 Eastern Ave. Balto MD 21224</i>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>OCT 01 1990</i>   |  | 32. REGISTRAR'S SIGNATURE<br><i>Lidia Davidson-Randall</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26781

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Lawrence M. Nypaver</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>26</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>Noon</b> <b>M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>174-22-0079</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                |  | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12-11-1917</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>PA.</b>   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>3414 Kimble Road</b> |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Woodlawn</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| 10a. STATE<br><b>MD</b>  |  |   |  | 10b. COUNTY<br><b>BALTO.</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>WOODLAWN</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>3414 KIMBLE RD</b>   |  | 10f. ZIP CODE<br><b>21207</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>CLAIMS EXAMINER</b>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>FEDERAL GOV'T.</b>   |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>ANDREW P. NYPAVER</b>  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ALICE NOVOTNY</b>  |  |   |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>MICHAEL NYPAVER</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1553 BARRETT RD. BALTO. MD. 21207</b>  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>WOODLAWN CEM.</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTO. MD.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>David J. Weber</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>EDWARD J. WEBER F.H.<br/>5311 EDMONDSON AVE.</b>   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Head injuries</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertensive arteriosclerotic cardiovascular disease</b> |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  | 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>9/26/90</b>   |  |
| 28b. TIME OF INJURY<br><b>M</b>  |  |   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Subject fell downstairs</b>  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Frank J. Peretti</i><br><b>Frank J. Peretti, M.D. - Assistant</b>   |  | 29c. LICENSE NUMBER<br><b>OCME</b>   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>9/27/90</b>  |  |   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>111 Penn St. Balto, MD ss</b>   |  | 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>  |  |
| 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26782

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Purnell Parker</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>28</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>9:20 P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-46-8468</b>  |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>42</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7-29-48</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Liberty Med. Center</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |   |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>1944 W. North Ave.</b>  |  |
| 10f. ZIP CODE<br><b>21217</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input checked="" type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input type="checkbox"/>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Unemployed</b>  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Phillip Parker Sr.</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Irene Alberta Hawkins</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. &amp; Mrs. William Parker</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>New Cathedral Cem</b>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>Balto. Md.</b>   |  |   |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joseph L. Russ</b>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph L. Russ Funeral Home</b><br><b>2222 W. North Ave. BALTO. MD. 21216</b>   |  |   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Pancreatitis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>Peritonitis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>Overwhelming Sepsis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate interval Between Onset and Death |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO   |  |   |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)   |  |   |  | 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide <b>6</b> <input type="checkbox"/> Could not be determined   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |  |  |
| 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Terrence Elder MD House Officer</b>  |  |   |  | 29c. LICENSE NUMBER<br><b>D38993</b>   |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>9/28/90</b>  |  |   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Terrence Elder MD 3001 South Hanover ST Balt MD.</b>   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the funeral home permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26783

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Raymond Pulliam</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>29</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>11:45 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>5-24-13</b>  | 8. BIRTHPLACE (State or Foreign Country)<br><b>NC.</b> |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Liberty Med. Center</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTO.</b>   |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>MD</b>   |  |  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTO.</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>2617 QUANTICO AVE</b>   |  | 10f. ZIP CODE<br><b>21215</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES         |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>NEGRO</b>  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>LABOR</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>Charlie Pulliam</b>  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HATTIE miles</b>  |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Annie Pulliam</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2617 Quantico Ave Balto Md 21215</b>               |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Woodlawn Cem.</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTO.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Botts Funeral Home</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>1129 N. Caroline St</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <b>Acute Respiratory Distress Syndrome</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Chronic obstructive Pulmonary Dz.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Overwhelming Sepsis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>Multiple cerebral Vascular accidents</b><br>Approximate interval Between Onset and Death |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>New onset Seizures</b><br><b>Congestive Heart Failure</b>  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Kerren Elderm House officer</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D38993</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/29/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Kerren Elder 3001 South Hanover St Baltimore MD 21236</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month/Day, Year)<br><b>OCT 01 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


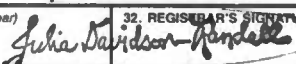
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26784

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>Regina A. Parish</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>29</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>11:28 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-12-7450</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>May 6, 1919</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACTORY NAME (If not institution, give street and number)<br><b>Stella Maris</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Towson</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>2300 Dulaney Valley Road</b>  |  |
| 10f. ZIP CODE<br><b>21204</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Sales</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Hochchilds</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James B. McDermott, Sr.</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Ann McKnight</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Jane McDermott Stiffler</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2520 Mantup Dr. Forest Hill, Md 21050</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Catonsville, Md.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Bryan W. Clary</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lemmon-Mitchell-Wiedefeld Inc.<br/>10 W. Padonia Road Timonium, Md 21093</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CA. of Breast with Mets.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |
| 29c. LICENSE NUMBER<br><b>D 25686</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/29/90</b>   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Ebrahim Ipakachi, MD 2300 Dulaney Valley Road Towson, Md 21204</b>                   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26785

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>EDWARD PRATT SR.   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>SEPTEMBER 29, 1990  |  | 3. TIME OF DEATH<br>5:15 A M  |  |
| 4. SOCIAL SECURITY NUMBER<br>220-16-6343   |  | 6. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br>66 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>3-4-24  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  | 9c. COUNTY OF DEATH<br>BALTIMORE CITY   |  |
| 10a. STATE<br>MARYLAND   |  |  |  | 10b. COUNTY<br>BALTIMORE  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE CITY   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 10e. STREET AND NUMBER<br>126 S. WASHINGTON STREET   |  |  |  | 10f. ZIP CODE<br>21231  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12TH GRADE  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>CARPENTER   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOHN PRATT  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>UNKNOWN  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>MARY E. BRINCK   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3495 ALBAN TOWNE WAY EDGEWOOD, MD 21040  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>ST. PATRICKS   |  | 20c. LOCATION — City or Town, State<br>MT SAVAGE, MD  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>David J. Weber  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>EDWARD J. WEBER F.H. 401 S. CHESTER ST  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. pneumonia   |  |  |  |   |  | 3 days  |  |
| b. carcinoma of lung   |  |  |  |   |  | 12 yrs.   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>metastatic disease   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 6 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
|  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Marianne Cannon   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-29-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARIANNE CANNON JOHN S HOPKINS ONCOLOGY CENTRE  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 01 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





90 26786

15  
1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MARIE C. Paar  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>SEPT. 26, 1990   |  | 3. TIME OF DEATH<br>1:10 A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>323-26-2423   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>86 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>MAY 22, 1904   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>SUMMIT NURSING HOME  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>CATONSVILLE   |  |
| 9c. COUNTY OF DEATH<br>BALTIMORE   |  |  |  | 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>BALTIMORE   |  |
| 10c. CITY, TOWN OR LOCATION<br>CATONSVILLE   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>421 S. ROLLING ROAD  |  |
| 10f. ZIP CODE<br>21228   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE  |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>12  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>HOMEMAKER   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>OWN HOME   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>TRUMAN SINDELL  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>CAROLINE CLAYGESS   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>LOUIS F. HUBER   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>810 LIGHT STREET, BALTIMORE, MARYLAND 21230   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>LOUDON PARK CEMETERY   |  |  |  |
| 20c. LOCATION — City or Town, State<br>BALTIMORE, MARYLAND   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br>LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES<br>1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cerebrovascular accident</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>ASCVD</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |
| 24. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>28b. TIME OF INJURY<br>28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>28d. DESCRIBE HOW INJURY OCCURRED<br>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>James E. Rowe MD</i><br>29c. LICENSE NUMBER<br>D13170<br>29d. DATE SIGNED (Month, Day, Year)<br>9/27/90  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>J. E. Rowe Summit Nursing Home Balt. Md</i>  |  |  |  | 31. DATE FILED (Month, Day, Year)<br>OCT 01 1990<br>REGISTRAR'S SIGNATURE<br><i>[Signature]</i><br>21228   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90-5475

ITEMS:23 thru 28f per ME G-668  
10-16-90 cm

90 26787

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Glenn T. Rose  |  |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 29 YEAR 90   |  | 3. TIME OF DEATH<br>4:56 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>219-86-9670   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>28 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Dec. 24, 1961   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Johns Hopkins Hospital   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City  |  |
| 9c. COUNTY OF DEATH<br>- - - -   |  |  |  | 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>- - - -   |  |
| 10c. CITY, TOWN OR LOCATION<br>BALTIMORE   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>917 N. LUZERNE AVE.  |  |
| 10f. ZIP CODE<br>21205   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) NA<br>Colleges (1-4 or 5+) NA   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>PAINTER  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>PAINTING   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>RICHARD RUNDLE ROSE   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>AUDREY CREAMER  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>ANDREY ROSE (MOTHER)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>917 N. LUZERNE AVE, BALTIMORE, MD. 21205  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>OAKLAWN CEMETERY   |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MD.  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>SCHIMUNEK FUNERAL HOMES, INC.<br>3331 BREHMS LANE, BALTIMORE, MD. 21213  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>NARCOTIC AND ALCOHOL INTOXICATION</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input checked="" type="checkbox"/> Pending Investigation<br>6 <input checked="" type="checkbox"/> Could not be determined   |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)<br>FOUND  |  |  |  | 28b. TIME OF INJURY<br>4:35p M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br>SUBJECT USED DRUGS AND ALCOHOL  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>FOUND: HOME  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>917 N. LUZERNE AVE<br>BALTIMORE CITY, MARYLAND   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br>OCME  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/30/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ann M. Dixon, M.D. 111 Penn St. Baltimore, Md. 21201  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 01 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26788

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mildred Louise RAINS</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 24, 1990</b>  |  |   |  | 3. TIME OF DEATH<br><b>8:28 p.m.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-20-8333</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>6-29-09</b>                |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Franklin Square Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rossville</b>  |  |   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| RESIDENCE OF DECEDENT   |  |  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Rosedale</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>8117 Pulaski Highway</b>   |  |  |  | 10f. ZIP CODE<br><b>21237</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                             |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 3rd grade</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Retired Seamstress</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Misty Harbor</b>                   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles Reid</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Daisy Ann Weiss</b>  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Norma J. Knauff</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8103 DuVall Avenue Baltimore, Maryland 21237</b>   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Moreland Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>       |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Lassahn Funeral Home</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Lassahn Funeral Home<br/>7401 Belair Rd. Balto., Md. 21236</b>  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Possible Aorta aneurysm or Rupture of Aorta (Thrombosis)</b><br>Approximate Interval Between Onset and Death<br>a. DUE TO (OR AS A CONSEQUENCE OF): <b>Arteriosclerosis</b><br>b. DUE TO (OR AS A CONSEQUENCE OF): <b>Bradycardia, old CVA, del. p. 1</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Tarique Firozvi</i>  |  |   |  | 29c. LICENSE NUMBER<br><b>D14221</b>  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |  |  | 29c. LICENSE NUMBER  |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9.26.90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Tarique Firozvi, M.D. 223 Eastern Blvd., Balto., 21221 (284-2400)</b>   |  |  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Rosdale</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be required by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26789

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |   |  |
|--|--|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DENISE L. ROGERS</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>27</b> YEAR <b>90</b>   |  |  |  | 3. TIME OF DEATH<br><b>9:00 P</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>238 66 8864</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>47</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>4-19-43</b>                     |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>WASHINGTON, D.C.</b>                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>HOWARD CO. GEN. HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>COLUMBIA</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>HOWARD</b>  |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>HOWARD</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>COLUMBIA</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><b>5406 ELCAMINO</b>   |  |  |  | 10f. ZIP CODE<br><b>21044</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A</b>                              |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>WRITER</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>PHH CORP.</b>                           |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>T.R. ROGERS</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ANN RUTH LATTIN</b>   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>RUTH E. FULP</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5103 FIELD HORN ROAD, GREENSBORO, N.C. 27406</b>  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CEDAR HILL CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>SUITLAND, MARYLAND</b>             |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY M. &amp; RUSSELL C. WITZKE FUNERAL HOMES</b><br><b>5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045</b>  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>Respiratory Arrest</b><br><b>Lung Cancer</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  |  | Approximate interval Between Onset and Death<br><b>10 min.</b><br><b>1 yr.</b>                        |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO           |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Warren M. Ross, M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D-17821</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/27/90</b>                        |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Warren M. Ross, M.D. 11065 Little Patuxent Pkwy, Col. MD 20849</b>   |  |  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





90 26790

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MADIAN G. STUMPTNER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>26</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>3:55 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>246 30 8948</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>65</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>05/02/25</b>                                   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>N. CAROLINA</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>HARBOR HOSPITAL CENTER</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                     |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  |  |  | 10a. STATE<br><b>MD.</b>  |  |   |  |
| 10b. COUNTY<br><b>BALTIMORE</b>   |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>DUNDALK</b>   |  |   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>1710 BROOKVIEW RD.</b>   |  |   |  |
| 10f. ZIP CODE<br><b>21222</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA.</b>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b><br>College (1-4 or 5+) <b>-</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>-</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>DANIEL PHELPS</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MAMIE BARNES</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Kenneth R. Stumptner</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1710 BROOKVIEW RD.</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MEADOW RIDGE</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Bryan Stump</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Connelly Funeral Home of Dundalk</i>   |  |   |  |
| 23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>LEFT LOWER LOBE PNEUMONIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>PANCYTOPENIA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>ACUTE LEUKEMIA</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dr. [Signature]</i> M.D.  |  |  |  | 29c. LICENSE NUMBER<br><b>D37810</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/28/90</b>                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CANTUS M. CHAVIR JR. HARBOR HOSPITAL CENTER 3001 S. HANOVER ST. BALTIMORE, MD 21230</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 1 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Rendell</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26791

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Margaret D. Seward</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> / DAY <b>22</b> / YEAR <b>90</b>   |  | 3. TIME OF DEATH<br>M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219 22 2350</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>4/4/1927</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>N.C.</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>117 Fleming Dr.</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Turners Station</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Balto.,</b>   |  |  |  | 10a. STATE<br><b>Md.</b>  |  | 10b. COUNTY<br><b>Balto.</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Turners Station, Md.</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>117 Fleming Dr.</b>   |  |
| 10f. ZIP CODE<br><b>21222</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Domestic</b>                    |  |
| 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>Arnold MC Donald</b>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Fannie Dempsey</b>  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>William M. Seward</b>   |  |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>117 Fleming Dr. Balto., Md. 21222</b>   |  | 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Arbutus</b>  |  | 20c. LOCATION — City or Town, State<br><b>Balto., Md.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James A. Morton</b>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>James A. Morton &amp; Sons<br/>1701 Laurens St. Balto., Md. 21217</b>   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>Myocardial infarction</b><br><b>CHF</b><br><b>D.M.</b><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> |  | Approximate Interval Between Onset and Death<br><b>1 HR</b><br><b>5 Yrs.</b><br><b>10 Yrs.</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO      |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  |
| 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John Conway MD</b>  |  | 29c. LICENSE NUMBER<br><b>D0 4636</b>  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>9/26/90</b>   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>6601 Chandler St, Balt, MD 21224</b>   |  | 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1172 00

90 26792

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |  |   |  |  |
|---|--|--|--|---|--|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Tyler Joseph SMITH</b>   |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 22, 1990</b>                  |   | 3. TIME OF DEATH<br><b>8:18 p<sup>m</sup></b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>Infant</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>0</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>0 1 0 18</b>                     |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>9-21-90</b>                             |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>Franklin Square Hospital Center</b>  |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>                          |   | 9c. COUNTY OF DEATH<br><b>Baltimore County</b>                                       |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |   |  |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  |  |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>7012 Park Heights Avenue Apt A2</b>  |  |  |  | 10f. ZIP CODE<br><b>21215</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                      |   |  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12)<br><b>Infant</b>  |  | College (1-4 or 5+)<br><b>Infant</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Infant</b>  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Infant</b>                         |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph Smith</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Tanya Latrice Lynn</b>  |  |  |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Joseph Smith</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7012 Park Heights Ave. Balt. Md 21215</b>   |  |  |   |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Woodlawn</b>   |  |  | 20c. LOCATION — City or Town, State<br><b>Balt. Md.</b>                 |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Wm. C. Brown</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM. C. BROWN Community F.H.<br/>1206 W. NORTH AVE</b>  |  |  |   |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |  |   |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |  |  |   |  |  |   |  |  |
| a. <b>Respiratory Distress Syndrome due to Prematurity</b>  |  |  |  |   |  |  |   |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |   |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |   |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |   |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |   |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |   |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |  |   |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |  |   |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | HOSPITAL:<br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA               |  | OTHER:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 26. PLACE OF DEATH (Check only one)  |   |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |   |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Kottapalli M.D.</b>   |  |  |  |   |  | 29c. LICENSE NUMBER<br><b>D22511</b>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/22/90</b>                                |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Sita Kottapalli, M.D., 9000 Franklin Square Drive, Baltimore, Maryland 21237</b>  |  |  |  |   |  |  |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>   |  |  |  |   |  |  |   |  |  |
| 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson</b>  |  |  |  |   |  |  |   |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ALBERT L. VIGILANTE</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>22</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>11:28 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>099-01-0817</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>SEPT. 18, 1910</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>NEW YORK</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Liberty Medical Center</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>   |  |
| 9c. COUNTY OF DEATH<br><b>--</b>  |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>--</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>3006 POPLAR TERRACE</b>   |  |
| 10f. ZIP CODE<br><b>21216</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>ADMINISTRATOR</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY (SECURITY)<br><b>MD. DEPT. OF EMPLOYMENT</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>SYLVESTER VIGILANTE</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ANNA HARRIS</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JOSEPH KAUFMAN</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>36 S. CHARLES STREET, SUITE 230, BALTIMORE, MD. 21201</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>LORRAINE PARK MAUSOLEUM</b>   |  | 20c. LOCATION — City or Town, State<br><b>WOODLAWN, MARYLAND</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY M. &amp; RUSSELL C. WITZKE FUNERAL HOMES<br/>1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Septic Shock</b><br><b>Multiple Sclerosis</b>  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><b>INSPECTION</b>   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)                                     |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>OCME</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-23-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Donald G. Wright, M.D., Deputy Chief 111 Penn Street, Baltimore, MD 21201 vl</b>  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26794


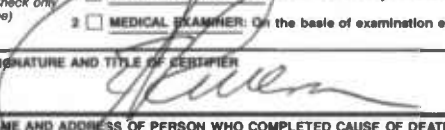
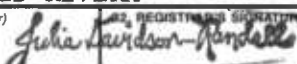
|   |  |  |  |   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ROZELLA WILLIAMS (Rosezella)  |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH 9 DAY 29 YEAR 90   |  | 3. TIME OF DEATH<br>11:59 PM  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>220389276  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>47 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>10-13-1942                                    |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>UNION MEMORIAL HOSPITAL   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY                                |  | 9c. COUNTY OF DEATH   |  |  |  |
| 10a. STATE<br>Md  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br>431 Manse Court   |  |  |  | 10f. ZIP CODE<br>21201  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black                  |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Instructor                         |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Art   |  |  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Thaddeus L. Thornton Sr.   |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Crenshaw                   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Thaddeus Thornton Jr.   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6620 Marott Dr. Balto., Md. 21215  |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Arbutus Memorial Cemetery Arbutus Maryland                             |  |   |  | 20c. LOCATION — City or Town, State  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Derrick C. Jones   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Derrick C. Jones F.H.<br>4611 Park Heights Ave. Balto., Md. 15  |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ESRD &amp; uremic encephalopathy</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b.<br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br> |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>McCue  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/30/90                                       |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Archana 8800 201 E Univ. Pkwy Baltimore, Md  |  |  |  |   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 01 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |  |   |  |  |  |



90 26795

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |   |   |  |
|--|--|--|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SADIE M. WIMMER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPT. 27 1990</b>  |   | 3. TIME OF DEATH<br><b>6:50 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-03-1745</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 17 1904</b>  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b> |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>BELAIR CONVALESARIUM</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |   | 9c. COUNTY OF DEATH<br><b>-----</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |   |   |  |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>-----</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |   | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>3223 LAWNVIEW AVE.</b>  |  |  |  | 10f. ZIP CODE<br><b>21213</b>   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                          |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b><br>College (1-4 or 5+) <b>N/A</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>OWN HOME</b>   |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WILLIAM HILE</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LILLIE KNICELY</b>  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>GEORGE J. WIMMER (SON)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9405 OAK WHITE RD., BALTIMORE, MD. 21236</b>  |   |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BALTIMORE NATIONAL CEM.</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD.</b>  |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SCHIMUNEK FUNERAL HOME INC.<br/>3331 Brehms Lane, Baltimore, Md. 21213</b>   |   |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEMENTIA</b><br><b>OLD CVA</b>  |  |  |  |   |   |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>D08344</b>  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/28/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. LUIS RIVERA 5714 Harford Rd., Baltimore, Md.</b>   |  |  |  |   |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>   |  |  |  |   |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26796

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>LANE, SR., JOHN WALTER  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>September 28 1990  |  | 3. TIME OF DEATH<br>2:35 P.M.  |   |
| 4. SOCIAL SECURITY NUMBER<br>215-01-7368  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>75 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>August 20 1915  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Richmond, Va.   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>5011 FREDERICK AVENUE  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore   |   |
| 9c. COUNTY OF DEATH   |  |  |  | 10a. STATE<br>Md   |  | 10b. COUNTY  |   |
| 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>5011 Frederick Avenue  |   |
| 10f. ZIP CODE<br>21229  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8th grade<br>College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Machinist  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Paper Company  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Ernest Lane  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>NELLIE THERESA O'CONNOR   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Richard Lane  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1303 Rice Avenue, Baltimore, MD 21228   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>London Park Cemetery   |  | 20c. LOCATION — City or Town, State<br>Baltimore   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Teresa L. Goff</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>HUBBARD FUNERAL HOME INC.<br>4107 WILKENS AVENUE, BALTIMORE, MD. 21229   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>myocardial infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>coronary artery disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>chronic obstructive pulmonary disease</i>  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Damian E. Birchess</i>   |   |
| 29c. LICENSE NUMBER<br>022114   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/28/90   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DR. DAMIAN E. BIRCHES, 5411 OLD FREDERICK RD., BALTIMORE, MD. 21229                             |   |
| 31. DATE FILED (Month, Day, Year)<br>OCT 01 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26797

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DAISY VIOLA WEIPPERT</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>30</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>1025 A</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-28-4982</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>April 13, 1915</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not Institution, give street and number)<br><b>North Arundel Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Anne Arundel</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Anne Arundel, Md</b>  |  |  |  | 10a. STATE<br><b>Md</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>7821 Waterview Avenue</b>   |  |
| 10f. ZIP CODE<br><b>21226</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b><br>College (1-4 or 6+) <b>HOMEMAKER</b>   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOMEMAKER</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Cook</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lillian ELizabeth Unknown</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Patsy L. Brown</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7821 Waterview Avenue, Baltimore, Md. 21226</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Glen Haven Cemetery</b>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>Baltimore</b>   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>M. Neal Coleman</b>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>Hubbard Funeral Home Inc.<br/>4107 Wilkens Avenue, Baltimore, Md. 21229</b>  |  |  |  | 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ACUTE CORONARY INSUFFICIENCY</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>ARTEROSCLEROTIC CARDIOVASC DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>HYPERTENSION</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>9-30-90</b>   |  |  |  |
| 28b. TIME OF INJURY<br><b>M</b>   |  |  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Charles A. Seager MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D33757</b>   |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>9-30-90</b>   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CHARLES A. SEAGER MD 108 ASHINGTON Rd SUPT</b>   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90 26798

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>GEORGE WIRTZ  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09 30 90  |  | 3. TIME OF DEATH<br>2.40 A. M.  |   |
| 4. SOCIAL SECURITY NUMBER<br>213-05-8405  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>76 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>February 11, 1914  |   |
| 8a. FACILITY NAME (If not institution, give street and number)<br>NORTH ARUNDEL HOSPITAL  |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br>GLEN BURNIE, MARYLAND  |  | 8c. COUNTY OF DEATH<br>A.A.   |   |
| 9a. RESIDENCE OF DECEDENT   |  |  |  | 9b. CITY, TOWN OR LOCATION  |  |   |   |
| 10a. STATE<br>Md  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>2809 Sunset Drive   |  |  |  | 10f. ZIP CODE<br>21223  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Upholster  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Monroe Upholstery   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Eugene Wirtz   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Edna Eisenhower  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>JoAnn S. Campbell   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>301 Beech Grove Ct., Millersville, MD. 21108   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>London Park Cemetery   |  | 20c. LOCATION — City or Town, State<br>Baltimore  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Hubbard Funeral Home Inc.<br>4107 Wilkens Avenue, Baltimore, Md. 21229  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Myocardial Infarction</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b.<br>c.<br>d.<br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |   |  |   |   |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>John Forman, M.D. Physician</u>   |  |  |  | 29c. LICENSE NUMBER<br>D23841   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/30/90  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DR. JONATHAN P. FORMAN, M.D. 7010 RITCHIE HIGHWAY GLEN BURNIE, MARYLAND 21061  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>OCT 01 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><u>Gale Davidson-Randell</u>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



90 26799

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BRANDON C. WATSON</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPTEMBER 27, 1990</b>   |  | 3. TIME OF DEATH<br><b>11:28P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>YRS. MONTHS DAYS<br><b>23</b>   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>July 14 1990</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>   |  |
| 10a. STATE<br><b>Md</b>  |  |  |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>2512 Brohawn Avenue</b>  |  |  |  |
| 10f. ZIP CODE<br><b>21230</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)                                    |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles E. Watson II</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Tracie A. Hurst</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Carol L. Hurst</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2512 Brohawn Avenue, Baltimore, Md. 21230</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial Park</b>                                       |  | 20c. LOCATION — City or Town, State<br><b>Baltimore</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James C. Smith</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hubbard Funeral Home Inc.<br/>4107 Wilkens Avenue, Baltimore, Md. 21229</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |   |  | 6 days   |  |
| a. <b>Staphylococcus sepsis</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  | 7 days   |  |
| b. <b>Central line catheter infiltrate</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  | 14 days  |  |
| c. <b>VA shunt placement</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  | 77 days  |  |
| d. <b>Prematurity</b>  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Grade IV intraventricular hemorrhage</b><br><b>Necrotizing enterocolitis with perforation</b><br><b>Branchopulmonary Dysplasia</b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Elizabeth L. Lister MD</i>   |  |
| 29c. LICENSE NUMBER  |  |  |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/28/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>600 NORTH WOLFE STREET BALTIMORE, MARYLAND 21205</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26800

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GARY WONG</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 25 1990</b>  |  | 3. TIME OF DEATH<br><b>7:35P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-40-2740</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>46</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>09 03 1944</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>BALTIMORE, MD</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>G.B.M.C.-6701 N. CHARLES STREET</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE, MD 21204</b>  |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE COUNTY</b>   |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>BALTIMORE COUNTY</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>513 NORTHPOINT RD</b>   |  |
| 10f. ZIP CODE<br><b>21224</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Beth Steel</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>BERNARD WONG</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>HELEN BROWN</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Bernard Wong</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>513 Northpoint Road Baltimore Md. 21224</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore Md.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Connelly Funeral Home</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Connelly FuenralHome of Dundalk 21222</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>brain stem tumor</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>M. So. M.D.</i>  |  |  |  |
| 29c. LICENSE NUMBER<br><b>D26250</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/26/90</b>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Matilda So. M.D. 1447 York Rd.</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 1 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26801

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Mary Williams</u>   |  |  |  | 2. DATE OF DEATH<br>MONTH <u>9</u> DAY <u>26</u> YEAR <u>90</u>   |  | 3. TIME OF DEATH<br><u>8:30</u> P.M.  |  |
| 4. SOCIAL SECURITY NUMBER<br><u>249 24 3184</u>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><u>74</u> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><u>May 8, 1916</u>                                   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><u>North Carolina</u>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><u>Liberty Medical Center</u>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Baltimore</u>                                     |  |
| 9c. COUNTY OF DEATH<br><u>n/a</u>  |  |  |  | 10a. STATE<br><u>Maryland</u>   |  |   |  |
| 10b. COUNTY<br><u>n/a</u>  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><u>Baltimore</u>   |  |   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><u>2703 Mosher St.</u>  |  |   |  |
| 10f. ZIP CODE<br><u>21216</u>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><u>Black</u>                  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>12</u><br>College (1-4 or 5+) <u>College</u>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><u>Homemaker</u>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Home</u>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>King Dudley</u>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Josephine Israel</u>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Mae Ravenell</u>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>Box 251, Sellers, SC 29592</u>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Mt. Zion Cemetery</u>   |  | 20c. LOCATION — City or Town, State<br><u>Sellers, SC</u>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Daniel J. Sellers</u>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><u>Capitol Funeral Service<br/>Falls Church, VA</u>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Cardiomyopathy</u>  |  |  |  |   |  |   | <u>Ten years</u>                             |
| a. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Malnutrition</u>  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><u>M</u>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>Lisa A. Simonson MD</u>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>9/27/90</u>                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Lisa A. Simonson MD 600 N Wolfe St, Baltimore MD 21205</u>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><u>OCT 01 1990</u>  |  | 32. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7

• • • U

 $\text{OH}$ 

077

# WELLS FARGO



90 26802

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GERTRUDE WELSH</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>26</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>5:00 A M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>183-24-4668</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>61</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>06-27-29</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pittsburgh, Pa.</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Good Samaritan Hosp.</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore Maryland</b>                                |   |
| 9c. COUNTY OF DEATH  |  |  |  | 10. RESIDENCE OF DECEDENT   |  |   |   |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Parkville</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>75 Ashlar Ct.</b>   |  |  |  | 10f. ZIP CODE<br><b>21234</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 years</b><br>College (1-4 or 5+) <b>2 years</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Commercial Artist</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Nancy Foreman Design</b>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William J. Maier</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Emma Dorothy Handte</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Kristen Welsh</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>75 Ashlar Ct. Balto. Md. 21234</b>   |  |   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md. 21229</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Edgar G. Ganshu</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>1150 Belair Rd. Kingsville Md. 21087</b>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Refractory hypotension</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Bacterial sepsis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Intraabdominal sepsis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Renal failure</b><br><b>Bleeding</b>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>R. Azar M.D. house officer</b>   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-26-90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Barbara Azar</b>   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90 26803

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Florence E. Williams</b>   |  |   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 29, 1990</b>                                     |  | 3. TIME OF DEATH<br><b>8:00 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219 18 0297</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2/14/16</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>823 Powers Street</b>  |  |   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH<br><b>Balto. City</b>   |  |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore City</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |   |  |
| 10e. STREET AND NUMBER<br><b>823 Powers Street</b>  |  |   |  | 10f. ZIP CODE<br><b>21211</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b></b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Arthur Franklin Ash</b>   |  |   |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Florence Rebecca Baker</b> |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charles O. Redmiles</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3720 Chestnut Avenue, Baltimore Md. 21211</b>   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Crestlawn Memorial</b>   |  | 20c. LOCATION — City or Town, State<br><b>Sykesville, Md.</b>                                   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Burgee-Henss Funeral Home<br/>3631 Falls Road, Baltimore, Md. 21211</b>  |  |   |  |   |  |
| 23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cancer Lung</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>15 mo</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|   |  |   |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Richard J. Diamond</i>  |  |   |  |   |  | 29c. LICENSE NUMBER<br><b>D23076</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>10-1-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. Richard Diamond 3730 Falls Road, Baltimore, Md. 21211</b>   |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26804

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JAMES WASHINGTON, JR</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>26</b> YEAR <b>1990</b>  |  | 3. TIME OF DEATH<br><b>7:21 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216 20 5185</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>62</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>4/17/28</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>North Arundel Hospital, 301 Hospital Drive</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Glen Burnie</b>   |  | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>  |  |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>A.A. Co.</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Glen Burnie</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>429 Azealea Pl.</b>   |  |  |  | 10f. ZIP CODE<br><b>21061</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE DATES<br><b>1950-1952</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 8+) <input type="checkbox"/>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Security Guard</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James N. Washington, Sr.</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Cornelia McWhite</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Diane L. Washington</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7884 Americana Apt. 202 Glen Burnie, Md. 21061</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Garrison Forest</b>   |  | 20c. LOCATION — City or Town, State<br><b>Owings Mills, Md.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James A. Morton</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>James A. Morton &amp; Sons<br/>1701 Laurens St. Balto., Md. 21217</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Renal Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Congestive Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>10 days</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Marc Okun MD</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D28000</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/26/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Marc Okun, M.D., 203 Hospital Drive, #206, Glen Burnie, Maryland, 21061</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 01 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Rendall</i>  |  |   |  |



10  
90 268051 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOHANNES J. WIERINGA</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>Sept</b> DAY <b>28</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>1:45 AM</b>  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-42-1279</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>02 19 20</b>                                   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>INDONESIA</b> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>UNION MEMORIAL HOSPITAL</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  |   | 9c. COUNTY OF DEATH  |  |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  |   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |
| 10e. STREET AND NUMBER<br><b>1010 Roland Heights Avenue</b>  |  |   |  | 10f. ZIP CODE<br><b>21211</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>NETHERLANDS</b>   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>4 YEARS</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>ACCOUNTANT</b>              |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>SELF-EMPLOYED</b>  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JAN WIERINGA</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>PAULINE DONK</b>  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DAISY WIERINGA</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1010 ROLAND HEIGHTS AVENUE, BALTO., MD. 21211</b>   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GREEN MOUNT CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD.</b>  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>A. ALAN SEITZ, JR. FUNERAL HOME<br/>3818 ROLAND AVENUE, BALTO., MD. 21211</b>  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Massive Intracerebral hemorrhage</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>HTN.</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br><b>NIDDM, COPD, HTN.</b> |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br><b>48 hr</b>   |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>NIDDM, COPD, HTN.</b>   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>N/A</b>  |  | 28b. TIME OF INJURY<br><b>N/A</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE NOW INJURY OCCURRED<br><b>N/A</b>              |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>N/A</b>  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>N/A</b>  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i><br><b>Mayet EL-Harake, MD</b>  |  |   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/28/90</b>                                       |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Mayet EL-Harake, MD / UNION MEMORIAL HOSPITAL</b>  |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 10 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90 26806

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MILTON WINSTEAD</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 27 90</b>   |  | 3. TIME OF DEATH<br><b>M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>245 20 4968</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>65</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>1 29 25</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>North Carolina</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>1702 THOMAS AVENUE</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  |
| 9c. COUNTY OF DEATH  |  |  |  | 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>1702 Thomas Avenue</b>   |  |
| 10f. ZIP CODE<br><b>21216</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>6/2/44 thru 6/28/46</b>   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Masket Cleaners</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Walter Winstead</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Emma</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Star W. Turner</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4703 Beaufort Avenue, Balto., Md 21215</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Bethel Church Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Wilson City, N.C.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>W. E. E. E.</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C. MARCH F.H. 4300 WABASH AVENUE</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Biliary Sepsis</b>  |  |  |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |  |  |  |  |   |  |
| b. <b>Obstructing Cholangio carcinoma</b>  |  |  |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |   |  |
| c. <b>Malnutrition</b>   |  |  |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |   |  |
| d. <b>Malnutrition</b>   |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Malnutrition</b>  |  |  |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Brent L. Norris</i><br><b>BRENT L. NORRIS</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>A44136435A2001</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-28-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BRENT L. NORRIS 225 S. Greene St UNIV. OF MD Baltimore, MD</b>   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 10 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


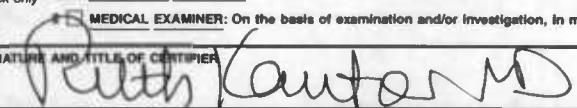
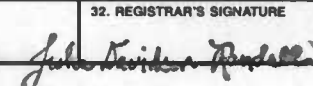
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26807

|   |  |  |  |   |   |  |   |  |  |   |  |
|---|--|--|--|---|---|--|---|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Dr. Ruth M. Allen M.D.  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept 28, 1990   |   | 3. TIME OF DEATH<br>3:15 P. M  |   |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>226-22-4180  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>66 YRS.   |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>3-27-24                                    |   | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>33 Glen Alpine Rd.  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Phoenix  |   |  | 9c. COUNTY OF DEATH<br>Baltimore  |  |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |   |  |   |  |  |   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Baltimore   |  | 10c. CITY, TOWN OR LOCATION<br>Phoenix  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |   |  |
| 10e. STREET AND NUMBER<br>33 Glen Alpine Rd.  |  |  |  | 10f. ZIP CODE<br>21131  |   | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |  |  |   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR DATES<br>Korea   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary [0-12] College (1-4 or 5+) 8 yrs   |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Physician |   |   | 16b. KIND OF BUSINESS/INDUSTRY<br>OB/GYN   |   |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>James Robert Allen   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Marie E. Becker  |   |  |   |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Janet D. Raffetto   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>33 Glen Alpine Rd. Phoenix, Md. 21131  |   |  |   |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Green Mount 10-1-90  |  |   | 20c. LOCATION — City or Town, State<br>Baltimore, Md. |  |   |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Ruck Towson Funeral Home, Inc<br>1050 York Road, Towson, Md. 21204  |   |  |   |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hepatic Failure<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Metastatic Small Cell Ca.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |   |  |   | Approximate Interval Between Onset and Death<br>1 mo<br>2 yrs                                  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |  |   |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |   |  |   |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br>Ruth Kantor M.D.  |  |  |  | 29c. LICENSE NUMBER<br>D28594   |   | 29d. DATE SIGNED (Month/Day/Year)<br>9/29/90   |   |  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ruth Kantor, M.D. 6565 N. Charles Street, Baltimore, Maryland  |  |  |  |   |   |  |   |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 2 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |   |  |   |  |  |   |  |

000000

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26808

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JUANITA FLORA ALSTON</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>28</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>3 45 AM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218011421</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>3 15 14</b>                                |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>2609 East Preston Street</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>MD</b>   |  |  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>                                      |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>2609 East Preston Street</b>   |  |  |  | 10f. ZIP CODE<br><b>21213</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>              |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5th Grade</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>None</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>N/A</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Lloyd Oliver</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Flora Collins</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Evelyn Herbert</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2609 East Preston St Baltimore, MD 21213</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mount Calvary</b>   |  | 20c. LOCATION — City or Town, State<br><b>Balto., MD</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Maggalean G. Henson</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Maggalean Gilmore Henson Funeral Service c/o Chatman-Harris F H 1701 McCulloh St Balto., MD</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Metastatic Breast Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b.<br>c.<br>d.<br>Approximate Interval Between Onset and Death<br><b>3 years</b> |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>H. Edward Fleming, Jr MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>E9913</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/30/90</b>                                |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>H. Edward Fleming, Jr MD Johns Hopkins Hospital Baltimore, MD</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 2 - 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Gulian Davidson-Randall</i>  |  |   |  |  |  |



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 90 26809

|  |  |   |                        |   |                                      |  |   |   |  |
|--|--|---|------------------------|---|--------------------------------------|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>LINDA AUGUSTUS   |  |   |                        | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09-26-90  |                                      | 3. TIME OF DEATH<br>M  |   |   |  |
| 4. SOCIAL SECURITY NUMBER<br>219-58-2718   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                        | 6. AGE (In yrs. last birthday)<br>39 YRS.   |                                      | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>09-07-51                                   |   | 8. BIRTHPLACE (State or Foreign Country)<br>MD.   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>1603 N. AISQUITH STREET  |  |   |                        | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE, MD.   |                                      |  | 9c. COUNTY OF DEATH   |   |  |
| 10a. STATE<br>MD   |  | 10b. COUNTY   |                        | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE, CITY  |                                      |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br>1603 N. AISQUITH STREET  |  |   | 10f. ZIP CODE<br>21218 |   | 10g. CITIZEN OF WHAT COUNTRY?<br>USA |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |                        | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                      |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK                                    |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12th  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>DISABLED   |                        | 16b. KIND OF BUSINESS/INDUSTRY  |                                      |  |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>EDWARD VAUGHN   |  |   |                        | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>CORA VAUGHN  |                                      |  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>HERMINA RUFUS  |  |   |                        | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1603 N. AISQUITH ST.-BALTIMORE, MD 21218   |                                      |  |   |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MT. ZION CEMETERY   |                        | 20c. LOCATION — City or Town, State<br>LANSDOWNE, MD.   |                                      |  |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |   |                        | 22. NAME AND ADDRESS OF FACILITY<br>WM.C. MARCH F.H. 1101 E. NORTH AVE.   |                                      |  |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Dilated cardiomyopathy<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |                        |   |                                      |  |   | Approximate Interval Between Onset and Death<br>Six years   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |                        |   |                                      |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                        |   |                                      |  |   |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |                        | 28b. TIME OF INJURY<br>M  |                                      | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |                        |   |                                      | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |   |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |                        |   |                                      |  |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Lisa A. Simonson MD</i>  |  |   |                        | 29c. LICENSE NUMBER   |                                      | 29d. DATE SIGNED (Month, Day, Year)<br>9-28-90                                       |   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Lisa A Simonson, MD 600 N Wolfe St, Baltimore MD 21205  |  |   |                        |   |                                      |  |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |                        |   |                                      |  |   |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 90 26810

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CHRISTOPHER LEE BEATTY</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 27 1990</b>  |  | 3. TIME OF DEATH<br><b>9:45pm</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-92-4389</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>25</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>4 7 1965</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Florida</b>   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>MIDDLETOWN ROAD</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>FREELAND, MD., 21053</b>   |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |   |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>BALTIMORE COUNTY</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Lineboro</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>21106 WEAVER ROAD</b>   |  |
| 10f. ZIP CODE<br><b>21088</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Laborer</b>  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Construction</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Herman M. Beatty</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Clara Belle Liggett</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Linda Ann Beatty</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>21106 Weaver Rd., Lineboro, MD 21088</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Vernon Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>White Hall, MD</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles T. Bowen</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>J.J. Hartenstein Mortuary, Inc.<br/>24 Second St., New Freedom, PA 17349</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <b>MULTIPLE INJURIES</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ROADWAY</b>  |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>9-27-90</b>  |  | 28b. TIME OF INJURY<br><b>6:30p</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Driver of m/c who crossed ctr. line...</b>   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>MIDDLETOWN ROAD</b>  |  |   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>Middletown Rd., FREELAND, MD. Baltimore County</b>  |  | 29a. CERTIFIER<br>(Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Mario F. Golle, Jr.</i>  |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-28-90</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Mario F. Golle, Jr., M.D., 111 PENN STREET, Balto., Md., 21201</b>   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26811

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>(Mark) Marc P. Beckles   |  |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 28 YEAR 90   |  | 3. TIME OF DEATH<br>8:10 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>218-96-4464   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>20 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>1-3-1970  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Windsor Mill Rd. & Allendale St.   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City  |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br>Md   |  |  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br>2114 Maryland Avenue   |  | 10f. ZIP CODE<br>21218   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>U S A   |  |  |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  |
| 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Guest Quarters Hotel   |  | 17. FATHER'S NAME (First, Middle, Last)<br>Melvin Beckles  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Frances Nichols   |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br>Melvin Beckles, Sr   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1420 Rosedale Street Baltimore, Md 21216  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery  |  | 20c. LOCATION — City or Town, State<br>Anne Arundel Co, Md   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Dola March  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>March F/H West<br>4300 Wabash Avenue   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple Gunshot Wounds<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) scene |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |
| 28a. DATE OF INJURY (Month, Day, Year)<br>9/28/90  |  |  |  | 28b. TIME OF INJURY<br>8:03P M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br>subject was shot  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>on street  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>Windsor Mill Rd. & Allendale St., Balto. City, Md.   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Ann M. Dixon, M.D.  |  | 29c. LICENSE NUMBER<br>OCME  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br>9/29/90   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ann M. Dixon, M.D. 111 Penn St. Baltimore, Md. 21201  |  | 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990   |  |
| 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |  |  | 33. DATE OF DEATH<br>90 26811  |  | 34. TIME OF DEATH<br>8:10 P M  |  |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

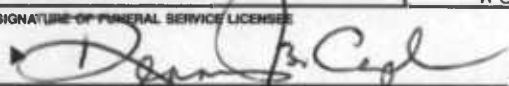
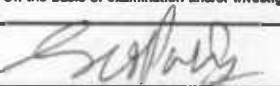
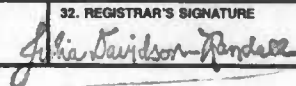
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |   |   |  |   |   |  |  | REG. NO. 90 26812                            |
|--|--|---|---|---|--|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CHARLES BRISCOE</b>   |  |   |   |   |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>27</b> YEAR <b>90</b>                            |   | 3. TIME OF DEATH<br><b>12:20 P.M.</b>  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-34-2649</b>  |  | 5. SEX<br><b>M</b> <input type="checkbox"/> F <input type="checkbox"/>  | 6. AGE (In yrs. last birthday)<br><b>52</b> YRS.  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>07-18-38</b>  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD</b>                        |   |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Liberty Medical Center</b>  |  |   |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  |   | 9c. COUNTY OF DEATH   |  |  |  |
| RESIDENCE OF DECEDENT  |  |   |   |   |  |   |   |  |  |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY   |   | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  |   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |
| 10e. STREET AND NUMBER<br><b>2012 Whittier Avenue</b>  |  |   |   | 10f. ZIP CODE<br><b>21217</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  |   | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>disabled</b> |   |  | 15b. KIND OF BUSINESS/INDUSTRY  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Charles B. Briscoe Sr.</b>   |  |   |   |   | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elizabeth Thomas</b> |   |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Elizabeth Briscoe</b>   |  |   |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2309 N. Monroe Street, Balto., MD 21217</b>   |  |   |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Western Star Cemetery</b>                        |   |  | 20c. LOCATION — City or Town, State<br><b>Catonsville, MD</b>                               |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |   | 22. NAME AND ADDRESS OF FACILITY<br><b>March Funeral Home-West, 4300 Wabash Avenue, Balto., MD 21215</b>  |  |   |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">{</div> <div> <p>b. DUE TO (OR AS A CONSEQUENCE OF): <b>METASTATIC LUNG CANCER</b></p> <p>c. DUE TO (OR AS A CONSEQUENCE OF): <b>with HYPERCEMIA</b></p> <p>d. DUE TO (OR AS A CONSEQUENCE OF):</p> </div> </div> |  |   |   |   |  |   |   |  |  | Approximate Interval Between Onset and Death |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DEHYDRATION with Cachexia.</b>  |  |   |   |   |  |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |
|  |  |   |   |   |  |   |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |   |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |   | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |   |  |   |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br> M.D.  |  |   |   | 29c. LICENSE NUMBER<br><b>D. 23300</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9.27.90</b>                                       |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SUDHIR. D. PATEL 2600 d'elaware Rd. BALTO MD. 212</b>  |  |   |   |   |  |   |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>  |  |   |   | 32. REGISTRAR'S SIGNATURE<br>  |  |   |   |  |  |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26813

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Blaine Blische</b>  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 29 1990</b>  |  | 3. TIME OF DEATH<br><b>M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-25-7280</b>  |  | 5. SEX<br><b>1 M 2 F</b>  |  | 6. AGE (In yrs. last birthday)<br><b>1</b> YRS.  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Sept. 22, 1989</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Mt. Washington Pediatric Hosp.</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Essex</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>  |  | 10e. STREET AND NUMBER<br><b>417 Maryland Ave.</b>  |  | 10f. ZIP CODE<br><b>21221</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b><br>IF YES, GIVE WAR OR DATES       |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 NO</b> Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) College (1-4 or 5+)</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>=====</b>                           |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>David Blische</b>  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sherrie Trish</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>David Blische</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>417 Maryland Ave. Baltimore Maryland 21221</b>      |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holly Hill Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore Maryland</b>                                 |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Connelly Funeral Home</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Connelly Funeral Home 300 Mace Ave. 21221</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. neurologic damage to meningitis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>b. due to group B strep meningitis</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>d.</b><br>DUE TO (OR AS A CONSEQUENCE OF): |  | Approximate Interval Between Onset and Death<br><b>10 mos</b><br><b>10 mos</b>  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>seizure disorder</b><br><b>preterm birth</b>  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 NO</b>   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b> |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 NO</b>  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b><br>OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |  |  |
| 27. MANNER OF DEATH<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                     |  |
| 29a. CERTIFIER (Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Swanna McCollery MD</i>   |  | 29c. LICENSE NUMBER<br><b>D35424</b>   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>9-29-90</b>  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Juli Davidson-Randall</i>   |  |  |  |

0111 02



DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. DECEDENT'S NAME (First, Middle, Last)  |  |  |                                | 2. DATE OF DEATH<br>MONTH DAY YEAR  |  |  |  | 3. TIME OF DEATH                       |  |   |  |   |  |
|---|--|--|--------------------------------|---|--|--|--|--|--|---|--|---|--|
| JAMES BERRY   |  |  |                                | SEPTEMBER 25, 1990  |  |  |  | 9:25 P.M.                              |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX   | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year) |  | 8. BIRTHPLACE (State or Foreign Country)  |  |   |  |
| 212-34-2787   |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                 | 53 YRS.                        | MONTHS DAYS   |  | HOURS MIN.   |  | 4/12/37                                |  | MD.   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |  |                                | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |  |  | 9c. COUNTY OF DEATH                    |  |   |  |   |  |
| MARYLAND GENERAL HOSPITAL   |  |  |                                | BALTIMORE, CITY   |  |  |  |  |  |   |  |   |  |
| 10a. STATE  |  |  |                                | 10b. COUNTY   |  |  |  | 10c. CITY, TOWN OR LOCATION            |  |   |  | 10d. INSIDE CITY LIMITS?  |  |
| MARYLAND  |  |  |                                |   |  |  |  | BALTIMORE, MARYLAND                    |  |   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER  |  |  |                                | 10f. ZIP CODE   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?          |  |   |  |   |  |
| 1058 Argyle Ave. Apt. 4 C   |  |  |                                | 21201   |  |  |  | USA                                    |  |   |  |   |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |                                | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)   |  | 14. RACE — American Indian, Black, White, etc.               |  |  |  |   |  |   |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |                                | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:   |  | Specify:<br>Black  |  |  |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)  |  |  |                                | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.) |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY         |  |   |  |   |  |
| Elementary/Secondary (0-12) College (1-4 or 5 +)  |  |  |                                |   |  |  |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |  |                                | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |  |  |  |  |   |  |   |  |
| William Berry   |  |  |                                | Beatrice Berry  |  |  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |  |                                | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)                 |  |  |  |  |  |   |  |   |  |
| Doretha Berry   |  |  |                                | 1058 Argyle Ave. Apt. 4C Balto. Md. 21201   |  |  |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION  |  |  |                                | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)  |  |  |  | 20c. LOCATION — City or Town, State    |  |   |  |   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |                                | Western Star Cem.   |  |  |  | Catonsville, Md.                       |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |  |                                | 22. NAME AND ADDRESS OF FACILITY  |  |  |  |  |  |   |  |   |  |
|   |  |  |                                | Estep Brothers Funeral Home P.A.<br>1300 Eutaw Pl. Balto. Md. 21217   |  |  |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |                                |   |  |  |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |  |                                |   |  |  |  |  |  |   |  |   |  |
| a. TERMINAL LUNG CARCINOMA WITH BONE METASTASIS   |  |  |                                |   |  |  |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |                                |   |  |  |  |  |  |   |  |   |  |
| b. CACHEXIA   |  |  |                                |   |  |  |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |                                |   |  |  |  |  |  |   |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |                                |   |  |  |  |  |  |   |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |                                |   |  |  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |                                |   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                         |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |                                |   |  |  |  |  |  | 26. PLACE OF DEATH (Check only one)   |  |   |  |
| HOSPITAL:<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA  |  |  |                                |   |  |  |  |  |  | OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |                                | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?   |  | 28d. DESCRIBE HOW INJURY OCCURRED      |  |   |  |   |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |                                | M   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER  |                                | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)                          |  |  |  |   |  |   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | ELIAS M. GIZAW, M.D.   |                                | n/a   |  | 9/25/90  |  |  |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |                                |   |  |  |  |  |  |   |  |   |  |
| ELIAS M. GIZAW, M.D. c/o MARYLAND GENERAL HOSPITAL  |  |  |                                |   |  |  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)   |  |  |                                | 32. REGISTRAR'S SIGNATURE   |  |  |  |  |  |   |  |   |  |
| OCT 02 1990   |  |  |                                |   |  |  |  |  |  |   |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  |   | REG. NO. 90 26815   |  |
|---|--|---|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Margaret Viola Barnett</i>   |  |   |  |  | 2. DATE OF DEATH<br>MONTH <i>9</i> DAY <i>28</i> YEAR <i>90</i> |   | 3. TIME OF DEATH<br><i>7:20 P.M.</i>   |
| 4. SOCIAL SECURITY NUMBER<br><i>212-10-0992</i>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><i>73</i> YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>11/20/16</i>  |   | 8. BIRTHPLACE (State or Foreign Country)<br><i>MD</i>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>St. Joseph Hospital</i>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Towson</i>   |   | 9c. COUNTY OF DEATH<br><i>Balto.</i>  |  |
| 10a. STATE<br><i>MD</i>   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><i>Balto.</i>   |   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>3403 Parkside Drive</i>  |  |   |  | 10f. ZIP CODE<br><i>21214</i>  |   | 10g. CITIZEN OF WHAT COUNTRY?   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>                      |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><i>Elementary/Secondary (0-12)</i>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Exec. Secretary</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Montebello State Hospital</i>   |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Ambrose F. Gardiner</i>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Catherine Michel</i>   |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>John F. Barnett Sr.</i>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>3403 Parkside Drive Baltimore, Md. 21214</i>   |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Green Mount</i>  |  | 20c. LOCATION — City or Town, State<br><i>Baltimore, Md.</i>   |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James F. Gladden</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Leonard J. Ruck Inc. 5305 Harford Rd. 21214</i>   |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac Arrest</i><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>b. <i>Renal Failure - Metabolic Acidosis</i></p> <p>c. <i>Metastatic Ovarian Cancer</i></p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death</p> </div> </div> |  |   |  |  |   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Renal Effusions</i>  |  |   |  |  |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |  |   |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br><i>M</i>   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Michael B. Dillon MD</i>                            |  |
| 29c. LICENSE NUMBER<br><i>D19110</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9/28/90</i>   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>M.B. DILLON, M.D., 550 N. BROADWAY BALTIMORE, MD 21205</i>   |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>OCT 02 1990</i>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |   |   |  |



DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | CERTIFICATE OF DEATH  |  | REG. NO. 90 26816   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Allen F. Benton  |  |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 28 YEAR 90  |  | 3. TIME OF DEATH<br>11 45 M   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>424-44-1066   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>56 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>1-5-34   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Alabama   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Baltimore County General Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Randallstown   |  | 9c. COUNTY OF DEATH<br>BALTO.   |  |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Baltimore   |  | 10c. CITY, TOWN OR LOCATION<br>Randallstown   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |   |  |
| 10e. STREET AND NUMBER<br>9702 Tulsemere Road  |  |  |  | 10f. ZIP CODE<br>21133  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>College (1-4 or 5+)<br>4 Years   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Systems Analyst                    |  | 16b. KIND OF BUSINESS/INDUSTRY<br>S.S.A.  |  |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Clarence C. Benton  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Alice Laval  |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Catherine Benton  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9702 Tulsemere Road Randallstown, MD 21133   |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Carroll Cremation Services   |  | 20c. LOCATION — City or Town, State<br>Hampstead, Maryland  |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>John K. Amundson  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Loring Byers Funeral Directors, Inc.<br>8728 Liberty Road Randallstown, MD 21133  |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA             |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)                        |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>John K. Amundson, M.D.  |  |   |  | 29c. LICENSE NUMBER<br>211171   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/29/90  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ed. William Saxe M.D., 5550 BALTO NAT'L PK CATONSVILLE  |  |  |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall - 21228-MD   |  |   |  |   |  |   |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26817

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JAMES BROWN SR.</b>   |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>28</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>241-10-3657</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS.   |  |
| 7. DATE OF BIRTH (Month, Day, Year)<br><b>4-12-15</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>S.C.</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1032 N. LUZERNE AVE.</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE, MD</b>   |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE, CITY</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>1032 N. LUZERNE AVE.</b>   |  | 10f. ZIP CODE<br><b>21205</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES    |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>6th</b> College (13-16) <b>4</b>  |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>BALTIMORE CITY</b>   |  | 17. KIND OF BUSINESS/INDUSTRY<br><b>WATER METERS</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JEFF BROWN</b>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY HENDERSON</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>REBECCA BROWN</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1032 N. LUZERNE AVE. - BALTIMORE, MD. 21205</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ARBUTUS MEMORIAL PARK</b>  |  | 20c. LOCATION — City or Town, State<br><b>ARBUTUS, MD.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Rebecca Brown</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes</b>  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>10/1/90</b>   |  |
| 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Rebecca Brown MD</i>   |  | 29c. LICENSE NUMBER<br><b>D15634</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>10/1/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>S. K. IATHANHAM MD 2323 Orleans Street Baltimore MD 21224</b>  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Jill Davidson-Randall</i>   |  |  |  |





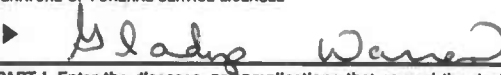
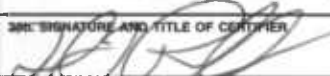
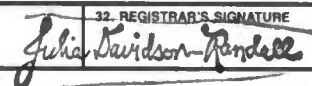
ITEM: 23pt1 per ME  
G-679 9/20/91 cm

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26818

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Donald L. Berkley</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>27</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>7:32 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-52-2944</b>  |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 8. AGE (In yrs. last birthday)<br><b>41</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>6-29-49</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1500 N. Rose Street</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  | 9c. COUNTY OF DEATH<br><b>MD.</b>  |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE, CITY</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>1500 N. ROSE STREET</b>   |  |  |  | 10f. ZIP CODE<br><b>21213</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br><b>3</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>ARMY</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: <b>XX</b>  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>12th</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>DISABLED</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>LONNIE COX</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>VIOLA BERKLEY</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>RAYMOND BERKLEY</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5214 BOWLEYS LN. APT-K-BALTIMORE, MD. 21206</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST VET. CEM.</b>   |  | 20c. LOCATION — City or Town, State<br><b>OWINGS MILLS, MD.</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>DIABETIC KETOACIDOSIS COMPLICATING CHRONIC ALCOHOLISM</b><br><b>Cirrhosis of liver</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>Chronic alcoholism</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic obstructive pulmonary disease</b>   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  |  |  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide<br><b>6</b> <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br><b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br><b>OCME</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/27/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Frank J. Peretti, M.D. - Assistant 111 Penn St. Balto, MD ss</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transfer permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the funeral director, page 5 should be detached for use as the burial certificate. Pages 1, 2, 3 should be filed within 72 hours after death with the funeral director, page 5 should be detached for use as the burial certificate.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 90 26819  |  |  |  |                                   |  |
|--|--|--|--|--|--|--|--|---|--|--|--|-----------------------------------|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |  |  |   |  |  |  |                                   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>WILLIAM M. BROWN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>27</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>M</b>   |  |   |  |  |  |                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>232-18-1883</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>72</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>4/11/1918</b>  | 8. BIRTHPLACE (State or Foreign Country)<br><b>S. CAROLINA</b> |  |  |   |  |  |  |                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>5202 FERNPARK (RESIDENCE)</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>   |  | 9c. COUNTY OF DEATH  |  |   |  |  |  |                                   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  |  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>                       |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |  |  |                                   |  |
| 10e. STREET AND NUMBER<br><b>5202 FERNPARK AVENUE</b>  |  |  |  | 10f. ZIP CODE<br><b>21207</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                |  |   |  |  |  |                                   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>5/14/42-11/24/43</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b> |  |   |  |  |  |                                   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |   |  |  |  |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>BENNIE BROWN</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY CARTER</b>  |  |  |  |   |  |  |  |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>IRVIN N. BROWN</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5202 FERNPARK AVE. BALTIMORE, MD 21207</b>   |  |  |  |   |  |  |  |                                   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CHELTENHAM CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>CHELTENHAM, MARYLAND</b>   |  |  |  |   |  |  |  |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy O. Dyett</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME<br/>4600 LIBERTY HEIGHTS AVENUE</b>   |  |  |  |   |  |  |  |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIO PULM OR ARRY ARREST</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>PANCREATIC CANCER</b> |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |  |  |  |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>9/27/90</b>                   |  | 28b. TIME OF INJURY<br><b>735A M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Alan A. Rosen M.D.</i>   |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/27/90</b>                      |  |   |  |  |  |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Alan A. Rosen, M.D. 222 W. Coldspring Lane Balto, MD 21210</b>   |  |  |  |  |  |  |  |   |  |  |  |                                   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>9/27/90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Gula Davidson-Randall</i>  |  |  |  |   |  |  |  |                                   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26820

|  |  |   |  |   |  |
|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Flora R Brown</b>   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>26</b> YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>7:28 A.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-20-9368</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>64</b> YRS.  |  |
| 7. DATE OF BIRTH<br>MONTH <b>10</b> DAY <b>29</b> YEAR <b>1925</b>   |  | 8. BIRTHPLACE (State or Foreign)<br><b>Maryland</b>   |  | 9. FACILITY NAME (If not institution, give street and number)<br><b>Homewood Hospital Center, South Baltimore</b>   |  |
| 10. STATE<br><b>MD.</b>  |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>2534 Calverton Heights Ave.</b>  |  | 10f. ZIP CODE<br><b>21216</b>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Retired</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Seamstress</b>   |  | 17. FATHER'S NAME (First, Middle, Last)<br><b>Unknown</b>   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Roberta Summerville</b>  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Eartha Adekoya</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7133 McClean Blvd. Balto., MD. 21234</b>  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Crestlawn Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Howard County, MD.</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>[Signature]</b> #281   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>E.L. Phillips Funeral Home<br/>1721-27 N. Monroe St. 21217</b>   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cerebral infarct</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>End stage Cardiomyopathy</b><br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus</b> |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>9/26/90</b>  |  |
| 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Marcelo B. Galicia MD</b>  |  | 29c. LICENSE NUMBER<br><b>D15698</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/26/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARCELO B. GALICIA MD, Homewood Hospital Center, South Balt. Md 21218</b>  |  | 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26821

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Louise H. Blynt  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-27-90   |  | 3. TIME OF DEATH<br>10:55AM M  |  |
| 4. SOCIAL SECURITY NUMBER<br>213-20-9601   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br>64 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>8-1-1926   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>3019 Pinewood Avenue   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City  |  | 9c. COUNTY OF DEATH<br>Maryland   |  |  |  |
| 10a. STATE<br>Pa.  |  | 10b. COUNTY<br>Erie  |  | 10c. CITY, TOWN OR LOCATION<br>Corry  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br>12 E. Congress St.   |  |  |  | 10f. ZIP CODE<br>16407  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12 Yrs.   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife                       |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Sylvester H. Hammer   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Rose C. Kowalewski   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Walter R. Blynt  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12 E. Congress St., Corry, Pa. 16407   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>St. Elizabeth Cem. 10-1-90   |  | 20c. LOCATION — City or Town, State<br>Corry, Erie Co., Pa.   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Roy H. Cather<br>Roy H. Cather  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Leonard J. Ruck, Inc., 5305 Harford Rd., Balto., Md. 21214  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic cardiovascular disease<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Rheumatoid Arthritis   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>INSPECTION  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) family members home |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
|  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Mario F. Golle, Jr., MD   |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-28-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARIO F. GOLLE, JR., MD 111 Penn Street, Baltimore, MD 21201  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26822

|   |  |   |  |   |  |  |  |   |  |   |  |
|---|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Celia Campoli   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9- 30- 90   |  |  |  | 3. TIME OF DEATH<br>10:10 a m   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>215-03-1658  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>83 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Feb. 3, 1907                               |  | 8. BIRTHPLACE (State or Foreign Country)<br>Italy   |  |   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br>Riverview Nursing Home  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Essex  |  |  |  | 9c. COUNTY OF DEATH<br>Baltimore  |  |   |  |
| 10a. STATE<br>Md.   |  |   |  | 10b. COUNTY<br>Baltimore  |  | 10c. CITY, TOWN OR LOCATION<br>Eastpoint   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br>7759 Eastdale Road  |  |   |  | 10f. ZIP CODE<br>21224  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>Italy   |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                  |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Tailor   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Frank Garbo  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Angelina Lamatina  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Angelina Wagner   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7759 Eastdale Road Balto. Md. 21224  |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery   |  | 20c. LOCATION — City or Town, State<br>Baltimore Md.  |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Connelly Funeral Home  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>ConnellyFuneralHome300MAceAve.21221   |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic Coronary Vascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Metastatic Carcinoma-Breast   |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Michael Schwartz MD  |  |   |  |   |  | 29c. LICENSE NUMBER<br>D19667  |  | 29d. DATE SIGNED (Month, Day, Year)<br>10-1-90  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>615 HARRISONS Lane Baltimore 21225   |  |   |  |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randell   |  |  |  |   |  |   |  |

2. 1944 - 1945  
1944/1945

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90426823

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>IDA B. CASEY</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>30</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>12:30 P.M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-10-6406</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8/27/02</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>POLAND</b>                                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St Joseph Hosp</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson, MD 21204</b>   |  | 9c. COUNTY OF DEATH<br><b>BALTO</b>   |  |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Parkville</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>2609 Wentworth Road</b>   |  |  |  | 10f. ZIP CODE<br><b>21234</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>X</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>X</b>   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>                           |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Borusewicz</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lena</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Richard W. Casey</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2609 Wentworth Road Baltimore, Md. 21234</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holy Rosary Oct. 3, 1990</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>James F. Gladden</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leonard J. Ruck Inc. 5305 Harford Rd. 21214</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>Massive Right Cerebral Ischemic Infarct</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Atherosclerotic Vascular Disease - Atrial Fibrillation</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Hypertension</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Atrial fibrillation, Congestive heart failure, Coronary vascular disease, peripheral vascular disease</b> |  |  |  |  |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atrial fibrillation, Congestive heart failure, Coronary vascular disease, peripheral vascular disease</b>   |  |  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>J. Chamik</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D36141</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-30-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>TAWFIK CHAMIK, MD<br/>2213 WOODBOX LANE, BALTIMORE, MD 21209</b>   |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b><br><b>Julia Davidson-Randall</b>   |  |  |  |  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

20/20

28

20/20-01-012

20/20

20/20

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. DECEDENT'S NAME (First, Middle, Last)   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR  |  |  |  | 3. TIME OF DEATH  |  |                     |  |                                     |  |
|--|--|--|--|---|--|--|--|---|--|---------------------|--|-------------------------------------|--|
| THOMAS H COOK Jr.  |  |  |  | SEPTEMBER 29 1990   |  |  |  | 5:45A M   |  |                     |  |                                     |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX   |  | 6. AGE (In yrs. last birthday)  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)   |  | 8. BIRTHPLACE (State or Foreign Country)  |  |                     |  |                                     |  |
| 217-56-6342  |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 36 YRS.   |  | 11/13/53   |  | MD  |  |                     |  |                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |  |  | 9c. COUNTY OF DEATH   |  |                     |  |                                     |  |
| ST. JOSEPH H Hosp.   |  |  |  | TOWSON  |  |  |  | BALTO.  |  |                     |  |                                     |  |
| 10a. STATE   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION   |  |  |  | 10d. INSIDE CITY LIMITS?  |  |                     |  |                                     |  |
| MD   |  |  |  | BALTO   |  |  |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |                     |  |                                     |  |
| 10e. STREET AND NUMBER   |  |  |  | 10f. ZIP CODE   |  | 10g. CITIZEN OF WHAT COUNTRY?  |  |   |  |                     |  |                                     |  |
| 1907 DRUIDHILL AVE.  |  |  |  | 21217   |  | USA  |  |   |  |                     |  |                                     |  |
| 11. MARITAL STATUS   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)                       |  | 14. RACE — American Indian, Black, White, etc. Specify:                              |  |   |  |                     |  |                                     |  |
| 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | BLACK  |  |   |  |                     |  |                                     |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)                        |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |   |  |                     |  |                                     |  |
| Elementary/Secondary (0-12)<br>College (1-4 or 5+)<br>4yrs.  |  | TEACHER  |  |   |  |  |  |   |  |                     |  |                                     |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |  |  |   |  |                     |  |                                     |  |
| THOMAS H. COOK SR.   |  |  |  | DELLA JACKSON   |  |  |  |   |  |                     |  |                                     |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)                                     |  |  |  |   |  |                     |  |                                     |  |
| WILLIAM E. TOLES   |  |  |  | 3708 FRANKFORD AVE.-BALTIMORE, MD. 21206  |  |  |  |   |  |                     |  |                                     |  |
| 20a. METHOD OF DISPOSITION   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | 20c. LOCATION — City or Town, State   |  |  |  |   |  |                     |  |                                     |  |
| 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | METRO CREMATORY  |  | BALTIMORE, MD.  |  |  |  |   |  |                     |  |                                     |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |  |  | 22. NAME AND ADDRESS OF FACILITY  |  |  |  |   |  |                     |  |                                     |  |
| Blaine Warner  |  |  |  | WM.C. MARCH F.H. 1101 E. NORTH AVE.   |  |  |  |   |  |                     |  |                                     |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |                     |  |                                     |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |   |  |  |  |   |  |                     |  |                                     |  |
| a. SEPSIS  |  |  |  |   |  |  |  |   |  |                     |  |                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |   |  |                     |  |                                     |  |
| b. HUMAN IMMUNE DEFICIENCY DISEASE   |  |  |  |   |  |  |  |   |  |                     |  |                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |   |  |                     |  |                                     |  |
| c.   |  |  |  |   |  |  |  |   |  |                     |  |                                     |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |   |  |                     |  |                                     |  |
| d.   |  |  |  |   |  |  |  |   |  |                     |  |                                     |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |                     |  |                                     |  |
|  |  |  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |                     |  |                                     |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)  |  |   |  |  |  |   |  |                     |  |                                     |  |
|  |  | HOSPITAL:<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA |  | OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |                     |  |                                     |  |
| 27. MANNER OF DEATH  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |                     |  |                                     |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  |  |  |   |  |  |  |   |  |                     |  |                                     |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |   |  |                     |  |                                     |  |
|  |  |  |  |   |  |  |  |   |  |                     |  |                                     |  |
| 29a. CERTIFIER<br>(Check only one)   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |   |  |  |  |   |  | 29c. LICENSE NUMBER |  | 29d. DATE SIGNED (Month, Day, Year) |  |
| 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | WILLIE E LAWRENCE JR M.D.  |  |   |  |  |  |   |  |                     |  | SEPTEMBER 29 1990                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |   |  |  |  |   |  |                     |  |                                     |  |
| WILLIE E LAWRENCE JR MD ST JOSEPH HOSPITAL TOWSON MD   |  |  |  |   |  |  |  |   |  |                     |  |                                     |  |
| 31. DATE FILED (Month, Day, Year)  |  |  |  |   |  |  |  |   |  |                     |  |                                     |  |
| OCT 02 1990  |  |  |  |   |  |  |  |   |  |                     |  |                                     |  |
| 32. REGISTRAR'S SIGNATURE  |  |  |  |   |  |  |  |   |  |                     |  |                                     |  |
| John Davidson-Randall  |  |  |  |   |  |  |  |   |  |                     |  |                                     |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26825

|  |  |  |   |  |  |  |  |
|--|--|--|---|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Eugene Coleman Jr.   |  |  |   | 2. DATE OF DEATH<br>MONTH 9 DAY 24 YEAR 1990   |  | 3. TIME OF DEATH<br>11:30 P.M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>219-90-0162   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br>27 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>11-08-62   |  | 8. BIRTHPLACE (State or Foreign Country)<br>MD.  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>UNION MEMORIAL HOSPITAL  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY  |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br>MD   |  |  |   | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE CITY  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |   | 10e. STREET AND NUMBER<br>409 McALLISTER STREET  |  | 10f. ZIP CODE<br>21202   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |   | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7th Grade<br>College (1-4 or 5+)   |  |  |   | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Disabled  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Eugene Coleman Sr.  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mattie Johnson  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Jean Coleman   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>409 McALLISTER ST./Baltimore, Md. 21202   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |   | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Voshell Mem. Park Cemetery   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Md.  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>W. C. March</i>  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>WM. C. MARCH 1101 E. NORTH AVENUE 21202  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Acquired Immunodeficiency Syndrome</i><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |  |   |  |  | Approximate interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                    |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |   | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  |  |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |   | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |   | 28e. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |   | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Carla A. Alexander</i>   |  |  |   | 29c. LICENSE NUMBER<br>D27087  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/28/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Stella Maris Hospice 2300 Dulaney Valley Rd Balt Md 21204</i>  |  |  |   |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990   |  |  |   | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randell</i>  |  |  |  |

6-28-55 02





1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26826

|  |  |   |  |   |  |  |  |   |  |   |  |
|--|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Joseph A. Cooke  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>10/01/90  |  | 3. TIME OF DEATH<br>M  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>75 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>03/12/15                                      |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br>St. Agnes Hospital CPER  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  |  |  | 9c. COUNTY OF DEATH   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Baltimore  |  | 10c. CITY, TOWN OR LOCATION<br>Lansdowne  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br>2013 Hammonds Ferry Road   |  |   |  | 10f. ZIP CODE<br>21227  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>0-8   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Guard  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Westinghouse mfg.   |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Marlene C. Lupton  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>36 Wade Avenue Catonsville, Maryland 21228   |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Glen Haven Cemetery   |  | 20c. LOCATION — City or Town, State<br>Glen Burnie, Maryland  |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Ambrose Funeral Home, Inc.<br>1328 Sulphur Spring Road 21227  |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → 1. Fatal Cardiac Arrhythmia<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { 2. Chronic obstructive lung disease<br>3. arterial hypertension<br>4. morbid obesity |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Physician  |  |  |  | 29c. LICENSE NUMBER<br>D29769   |  | 29d. DATE SIGNED (Month, Day, Year)<br>10/1/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Marlene C. Lupton 516 W. Rolling Rd Baltimore 21228   |  |   |  |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 2 1990  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |   |  |   |  |

1848 62

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  | CERTIFICATE OF DEATH  |  | REG. NO. 90 26827   |   |
|--|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>John Conway</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>9</i> DAY <i>29</i> YEAR <i>90</i>   |  | 3. TIME OF DEATH<br><i>1140 AM</i>  |   |
| 4. SOCIAL SECURITY NUMBER<br><i>229-01-1119</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>86</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>3-31-04</i>  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Liberty Medical Center</i>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore</i>   |  | 9c. COUNTY OF DEATH   |   |
| 10a. STATE<br><i>MD.</i>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><i>Baltimore</i>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><i>Dukeland Nursing Home</i>   |  |  |  | 10f. ZIP CODE<br><i>21216</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>Black</i>                         |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Retired</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Domestic</i>   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Eliash Taylor</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Liggy Braxton</i>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>George Conway</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>Route 3 Box 394 Lancaster, Virginia 22503</i>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>King Mem. Park</i>  |  | 20c. LOCATION — City or Town, State<br><i>Balto, MD.</i>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Dorothy Hector #281</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>E.L. Phillips Funeral Home<br/>1721-27 N. Monroe St. 21217</i>   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Ventricular Arrhythmia</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>b. Renal Insufficiency</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>c. Multiple Myeloma</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>d.</i> |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Bilateral Mastectomy</i><br><i>Old Ant-Septal MI</i><br><i>Congestive Heart Failure</i><br><i>Gouty Arthritis</i>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>B. Kutsche MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>D-35788</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9/29/90</i>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>B. Kutsche LIBERTY MED CENTER BALTIMORE, MD 21215</i>  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><i>OCT 02 1990</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |   |

1967-70

1

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate. 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |  |   |  |
|---|--|--|--|--|--|--|--|---|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CHARLES V. CLARKE</b>  |  |  |  |  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>25</b> YEAR <b>90</b>   |  |  |  | 3. TIME OF DEATH<br><b>12 25</b> M  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>265-28-0710</b>   |  |  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>67</b> YRS. |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b> |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>9-27-1922</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD.</b>  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>ST. JOSEPH HOSP.</b>   |  |  |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TOWSON</b>  |  |  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>   |  |  |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>OWINGS MILLS</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>1 SHASTA CIRCLE</b>  |  |  |  |  |  |  |  | 10f. ZIP CODE<br><b>21117</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                            |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>N/A</b><br>College (1-4 or 5+) <b></b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>WAREHOUSE</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>DEPT. STORE</b>  |  |  |  |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN PELHAM CLARKE</b>  |  |  |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>FLORENCE McNISH</b>   |  |  |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARGARET N. WALKER</b>   |  |  |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2715 N. CALVERT ST. BALTIMORE, MD. 21218</b>  |  |  |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>LORRAINE PARK CEM.</b>  |  |  |  | 20c. LOCATION — City or Town, State<br><b>WOODLAWN, MD. 21207</b>   |  |  |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>William R. Davis III</b>  |  |  |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>4905 YORK ROAD 21212<br/>H.W. JENKINS AND SONS. BALTO. MD</b>  |  |  |  |   |  |   |  |   |  |
| 23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>a. Metastatic Renal cell Carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Atherosclerotic cardiovascular disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. Acute myocardial infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. Dehydration / Renal Failure</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>                  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED                |  |   |  |   |  |   |  |
|   |  |  |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>H. Bassi M.D.</b>   |  | 29c. LICENSE NUMBER<br><b>D37250</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/25/90</b> |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ASHWANI K. BASSI M.D. ST. JOSEPH HOSPITAL BALTIMORE MD.</b>   |  |  |  |  |  |  |  |   |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 2 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia K. Anderson-Randall</b>  |  |  |  |   |  |  |  |   |  |   |  |   |  |



5430

ITEMS: 23 thru 28f per ME  
G-668 10-22-90 cmFOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26829

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Ray W. Dean   |  |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 27 YEAR 90  |  | 3. TIME OF DEATH<br>10:19PM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>214-50-7010  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>42 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>02-12-1948  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Virginia  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>2209 Eastern Avenue   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  |
| 9c. COUNTY OF DEATH   |  |  |  | 10a. STATE<br>Maryland  |  | 10b. COUNTY   |  |
| 10c. CITY, TOWN OR LOCATION<br>Baltimore City   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |
| 10e. STREET AND NUMBER<br>2428 Foster Avenue  |  |  |  | 10f. ZIP CODE<br>21224  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12th Grade   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Carpenter   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Union #101  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>George Dean  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Virginia Bandy   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Elwood E. Cadle   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2428 Foster Avenue, Baltimore, MD 21224  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery 10/1/90  |  | 20c. LOCATION — City or Town, State<br>Glen Burnie, MD  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Avenue, Baltimore, MD 21222  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>NARCOTIC &amp; ALCOHOL INTOXICATION</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
|   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) house |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation<br>6 <input checked="" type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br>FOUND 9-27-90   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>UNKNOWN   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>2209 EASTERN AVENUE<br>BALTIMORE, MARYLAND  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-27-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARIO F. GOLLE, JR., MD 111 Penn Street, Baltimore, MD 21201   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 2 1990   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





90-5522-510

90-5522

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26830

|  |  |                                 |  |   |  |  |  |
|--|--|---------------------------------|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Charles Ellsworth Davidson</b>  |  |                                 |  | 2. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>1</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>12:30 a.m.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-01-9242</b>  |  | 5. SEX<br><b>1</b> M <b>2</b> F |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>4-6-19</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Balto. Md.</b>  |  |                                 |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Good Samaritan Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore, MD.</b>                                     |  |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |                                 |  | 10a. STATE<br><b>MD.</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |                                 |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> YES <b>2</b> NO  |  | 10e. STREET AND NUMBER<br><b>2819 Ontario Avenue</b>   |  |
| 10f. ZIP CODE<br><b>21234</b>  |  |                                 |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br><b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO<br>IF YES, GIVE WAR OR DATES  |  |                                 |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> YES <b>2</b> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |                                 |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2</b> yrs. College (1-4 or 5+) <b>2</b> yrs.  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Tower Operator</b>                          |  |                                 |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>B &amp; O R.R.</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Milton L. Davidson</b>   |  |                                 |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Theresa Krebs</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dorothy Elaine Sauer</b>  |  |                                 |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3134 Tracey Store Road Parkton, Md.-21120</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)                   |  |                                 |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>  |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b>   |  |                                 |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>John C. Miller, Inc.</b>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>6415 Belair Road Baltimore, MD.-21206</b>   |  |                                 |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardio-pulmonary arrest</b><br><b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b><br><b>Renal failure</b><br><b>Coronary artery disease</b><br><b>Upper GI bleeding</b> |  |  |  |
| 24. WAS AN AUTOPSY PERFORMED?<br><b>1</b> YES <b>2</b> NO<br><b>?</b>  |  |                                 |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> YES <b>2</b> NO<br><b>X</b>   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> YES <b>2</b> NO<br><b>X</b>   |  |                                 |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA<br>OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br><b>1</b> Natural <b>2</b> Pending Investigation <b>3</b> Accident <b>4</b> Suicide <b>5</b> Homicide <b>6</b> Could not be determined |  |                                 |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>9/26/90</b>  |  |  |  |
| 28b. TIME OF INJURY<br><b>10:00P M</b>   |  |                                 |  | 28c. INJURY AT WORK?<br><b>1</b> YES <b>2</b> NO<br><b>X</b>  |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>subject fell</b>   |  |                                 |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>home</b>   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>2819 Ontario Ave., Balto. City, Md.</b>                                   |  |                                 |  | 29a. CERTIFIER (Check only one)<br><b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>CERTIFICATION APPROVED BY MEDICAL EXAMINER</b>  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>WAIL ASSY PAYEE</b>  |  |                                 |  | 29c. LICENSE NUMBER   |  |  |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>10/1/90</b>  |  |                                 |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Wail Assy</b>   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>  |  |                                 |  | 32. REGISTRAR'S SIGNATURE<br><b>Gina Davidson-Pendell</b>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached to the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 5 should be detached and filed with the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26831

|   |  |   |  |   |  |  |   |  |  |
|---|--|---|--|---|--|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Florence Dabett</i>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9 27 90   |  | 3. TIME OF DEATH<br>1:15 P M   |   |  |  |
| 4. SOCIAL SECURITY NUMBER<br>181-32-0305  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>84 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>11/26/05                                   |   | 8. BIRTHPLACE (State or Foreign Country)<br>Harrisburg, PA |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Joseph Richey House</i>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore</i>   |  |  | 9c. COUNTY OF DEATH   |  |  |
| 10a. STATE<br>Pennsylvania  |  | 10b. COUNTY<br>Berks  |  | 10c. CITY, TOWN OR LOCATION<br>Reading  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |
| 10e. STREET AND NUMBER<br>1517 Hill Road  |  |   |  | 10f. ZIP CODE<br>19602  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |   |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                             |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12)<br>College (1-4 or 5+)<br><i>+ 4</i>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Domestic |  |   |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Simon Frank  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Deborah Unknown  |  |  |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Suzon Weber   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6 Barstat Court, Lutherville, MD 21093   |  |  |   |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Baltimore Hebrew Cong. Cemetery   |  | 20c. LOCATION — City or Town, State<br>Reisterstown, MD   |  |  |   |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael P. Marzullo</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Hebrew Memorial Funeral Home, Inc.<br>1100 Reisterstown Rd., Baltimore, MD 21208  |  |  |   |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <i>Respiratory arrest</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Expanding brain tumor</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>presumably high grade glioma</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>Approximate Interval Between Onset and Death<br><i>5mo</i> |  |   |  |   |  |  |   |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  |   |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |  |   |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <i>Residence</i> |  |   |  |  |   |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED                          |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |   |  |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |   |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John W. Payne, M.D.</i>   |  |   |  | 29c. LICENSE NUMBER<br><i>D 13012</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>27 Sept 90</i>                             |   |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>14 W. W. Verma Place Baltimore 21201</i>  |  |   |  |   |  |  |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>OCT 02 1990</i>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |  |  |   |  |  |



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26832

|   |  |   |  |   |  |   |                                  |   |  |  |  |
|---|--|---|--|---|--|---|----------------------------------|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>William Conrad Davis Sr.  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 28 1990   |  | 3. TIME OF DEATH<br>11:15am   |                                  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>216-09-0303  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>79 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Nov. 16, 1910   |                                  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>304 Lorraine Ave.   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Essex  |  |   | 9c. COUNTY OF DEATH<br>Baltimore |   |  |  |  |
| 10a. STATE<br>Md.   |  |   |  | 10b. COUNTY<br>Baltimore  |  | 10c. CITY, TOWN OR LOCATION<br>Essex  |                                  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br>304 Lorraine Ave.   |  |   |  | 10f. ZIP CODE<br>21221  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |                                  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                             |                                  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)<br>8th   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Fire Fighter   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Beth Steel  |                                  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Lambert C. Davis   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Anna Frank   |  |   |                                  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>William C. Davis Jr.  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>802 Arncliffe Road Baltimore Md.   |  |   |                                  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Gardens of Faith Cemetery   |  | 20c. LOCATION — City or Town, State<br>Rossville Md.  |  |   |                                  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Connelly Funeral Home  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Connelly Funeral Home 300 MAce Ave. 21221   |  |   |                                  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Obstructive pulmonary Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   |                                  | Approximate Interval Between Onset and Death<br>15 yrs.   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Carcinoma of prostate   |  |   |  |   |  |   |                                  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                           |  | OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 26. PLACE OF DEATH (Check only one)   |                                  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |                                  |   |  |  |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>M. Rainess, M.D.   |  | 29c. LICENSE NUMBER<br>D 12913  |  | 29d. DATE SIGNED (Month, Day, Year)<br>10-1-90  |                                  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MORRIS RAINESS, M.D. 1105 OLD EASTERN AVE. 21221   |  |   |  |   |  |   |                                  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |   |                                  |   |  |  |  |



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

90 26833

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>LAWRENCE DELIA, JR.   |  |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 26 YEAR 1990  |  | 3. TIME OF DEATH<br>11:00 P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>220 18 4139  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>66 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>04-09-24   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>VA MEDICAL CENTER   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>FORT HOWARD   |  |
| 9c. COUNTY OF DEATH<br>BALTIMORE  |  |  |  | 10a. STATE<br>MARYLAND  |  | 10b. COUNTY<br>ANNE ARUNDEL  |  |
| 10c. CITY, TOWN OR LOCATION<br>PASADENA   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br>1525 ROCK CREEK WAY  |  |
| 10f. ZIP CODE<br>21122  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>2/5/43-12/2/45  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10 th grade<br>College (1-4 or 5+) none   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>MAINTENANCE ENGINEER   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>BALTIMORE GAS/ELECTRIC   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>LAWRENCE DELIA   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>LOUISE KRONER  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>CLINICAL RECORDS  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>VA MEDICAL CENTER, FT HOWARD, MD 21052   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>LOUDON PARK CEMETERY, BALTIMORE, MARYLAND   |  | 20c. LOCATION — City or Town, State  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Shane A. Savage  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>MC CULLY FUNERAL HOME OF PASADENA<br>3204 MOUNTAIN RD., PASADENA, MD 21122  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARCINOMA OF LUNG<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>MULTIPLE SCLEROSIS<br>ANEMIA  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE NOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>[Signature]  |  |  |  | 29c. LICENSE NUMBER<br>D30528   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/27/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>M. BALA DUGGIRALA, MD., VA MEDICAL CENTER, FT HOWARD, MD. 21052  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rossell   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26834

1 - FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>VICTOR E. DAVILA</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> - DAY <b>30</b> - YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>6:00P. M</b>   |   |
| 4. <b>218-11-0975</b><br><b>582-42-4516</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs last birthday)<br><b>42</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year) <b>10/19/47</b>  |   |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>Joseph Richey Hospice</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  | 9c. COUNTY OF DEATH<br><b>City</b>  |   |
| 10a. STATE<br><b>MD.</b>  |  | 10b. COUNTY<br><b>BALTIMORE</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>HILLENDALE</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>6806 COLLINSDALE ROAD</b>  |  |   |  | 10f. ZIP CODE<br><b>21234</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: <b>ECUADOR &amp; PUERTO RICAN</b> |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>4</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>DEPT. OF EDUCATION</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>EDUCATION ( PERSONAL)</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>DAVID E. DAVILA</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ROSA BOBE</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MILAGROS DAVILA</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6806 COLLINSDALE ROAD BALTIMORE, MD. 21234</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MORELAND MEM. PARK</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD. 21234</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Edm. M. Perkins</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HENRY W. JENKINS AND SONS CO.<br/>4905 YORK ROAD BALTIMORE, MD. 21212</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory arrest</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Due to (or as a consequence of):</b><br><b>Cryptosporidium diarrhea</b><br>b. <b>Due to (or as a consequence of):</b><br><b>Retrovirus infection</b><br>c. <b>Due to (or as a consequence of):</b><br>d. |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Hospice</b>   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |   |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>John W. Paine, M.D.</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D13012</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>10 Oct 90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>14 W. M. Vernon Place Baltimore 21201</b>   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 2 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be deposited with the funeral director as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.




90 26835

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MINOR ESKLINE</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9-28-90</b>  |  | 3. TIME OF DEATH<br><b>9:50 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>227-30-0065</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>67</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>3-12-23</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>BON SECOUR HOSP.</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE, MD.</b>  |  | 9c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE, CITY</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>2100 WALBROOK AVE.</b>   |  |  |  | 10f. ZIP CODE<br><b>21217</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th</b><br>College (1-4 or 5+) <b>College</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>NURSES AIDE</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>SAMUEL KNUCKLES</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>RACHEL ROBERTSON</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARY MINOR</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3403 ELMORA AVE.-BALTIMORE, MD. 21213</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BALTIMORE CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Headsman</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  | a. <b>Cardiac artery thrombosis</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  | b. <b>chronic renal failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|   |  | c. <b>Hypertension</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |
|   |  | d.   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Suresh K. Tripathi</b>   |  | 29c. LICENSE NUMBER<br><b>D30661</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/29/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Suresh K. TRIPATHI, Bon Secours hospital.</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>  |  |   |  |   |  |



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Ruth H. Flournoy   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-18-90   |  | 3. TIME OF DEATH<br>6:18PM M  |  |
| 4. SOCIAL SECURITY NUMBER<br>467-12-2354   |  | 6. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>86 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>8-31-1904   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>?  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>9704 Goodluck Road  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Lanham   |  | 9c. COUNTY OF DEATH<br>Prince Georges Co.   |  |
| 10a. STATE<br>Md.  |  |   |  | 10b. COUNTY<br>Prince Georges Co.   |  | 10c. CITY, TOWN OR LOCATION<br>Lanham, Md.  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br>9704 Goodluck Rd.   |  |   |  |
| 10f. ZIP CODE<br>21222   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) College (1-4 or 5+)<br>Unknown   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Unknown   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Unknown  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Michael S. Welling   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>503 E. Street N.W. Washington, D.C. 20001  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Greenmount Crematory  |  | 20c. LOCATION — City or Town, State<br>Balto., MD.  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Bradley-Ashton FUNeral Home, INC.<br>2134 Willow Spring Rd. Dundalk, Md. 21222  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Contact gunshot wound of head<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently that conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br>9-18-90  |  | 28b. TIME OF INJURY<br>FOUND 5:30PM   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br>Self inflicted wound  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>Home  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>9704 Goodluck Road, Lanham, Prince Georges County, MD   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |   |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-19-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>ANN M. DIXON, MD 111 Penn Street, Baltimore, MD 21201   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

BALTIMORE, MARYLAND 21206-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the funeral home or transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician after death. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |                     |  | REG. NO. 90 26837   |  |                                   |  |
|---|--|--|--|--|--|---------------------|--|---|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |  |  | 2. DATE OF DEATH   |  |                     |  | 3. TIME OF DEATH  |  |                                   |  |
| CLARA G. FISHER   |  |  |  | 09 28 90   |  |                     |  | 10:20 A.M.  |  |                                   |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX   |  | 6. AGE (In yrs. last birthday)   |  | 7. DATE OF BIRTH    |  | 8. BIRTHPLACE (State or Foreign Country)  |  |                                   |  |
| 216-24 4318   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 72 YRS.  |  | 02-03-18            |  | VIRGINIA  |  |                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |                     |  | 9c. COUNTY OF DEATH   |  |                                   |  |
| BON SECOURS HOSPITAL  |  |  |  | BALTIMORE  |  |                     |  |   |  |                                   |  |
| 10a. STATE  |  |  |  | 10b. COUNTY  |  |                     |  | 10c. CITY, TOWN OR LOCATION   |  |                                   |  |
| MARYLAND  |  |  |  |  |  |                     |  | BALTIMORE   |  |                                   |  |
| 10d. INSIDE CITY LIMITS?  |  |  |  | 10e. STREET AND NUMBER   |  |                     |  | 10f. ZIP CODE   |  |                                   |  |
| 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 2528 W. MOSHER STREET  |  |                     |  | 21216   |  |                                   |  |
| 11. MARITAL STATUS  |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |  |                     |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) |  |                                   |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married  |  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |                     |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                     |  |                                   |  |
| 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  |  | IF YES, GIVE WAR OR DATES  |  |                     |  | Specify:  |  |                                   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |                     |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |                                   |  |
| Elementary/Secondary (0-12) College (1-4 or 5+)   |  |  |  | PACKER   |  |                     |  | DIMANO SUGAR PLANT  |  |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |                     |  |   |  |                                   |  |
| MARYUS GRAVES   |  |  |  | CLARA FIELDS   |  |                     |  |   |  |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |                     |  |   |  |                                   |  |
| EDWARD K. FISHER  |  |  |  | 2528 W. MOSHER STREET BALTIMORE, MARYLAND 21216  |  |                     |  |   |  |                                   |  |
| 20a. METHOD OF DISPOSITION  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  |                     |  | 20c. LOCATION — City or Town, State   |  |                                   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State   |  |  |  | GARRISON FOREST VET. CEM. 10/1/90 OWINGS MILLS, MD.  |  |                     |  | BALTO   |  |                                   |  |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  |  |  |                     |  | CO.   |  |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |  |  | 22. NAME AND ADDRESS OF FACILITY   |  |                     |  |   |  |                                   |  |
| Lewis T. Gwynn  |  |  |  | LEWIS T. GWYNN FUNERAL HOME 21215-6393   |  |                     |  |   |  |                                   |  |
|   |  |  |  | 4517 PARK HEIGHTS AVE BALTIMORE MARYLAND   |  |                     |  |   |  |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  |  |  |  |  |                     |  | Approximate Interval Between Onset and Death  |  |                                   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |  |  |  |  |                     |  |   |  |                                   |  |
| a. cerebro vascular accident  |  |  |  |  |  |                     |  |   |  |                                   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |                     |  |   |  |                                   |  |
| b. Hypertension   |  |  |  |  |  |                     |  |   |  |                                   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |                     |  |   |  |                                   |  |
| c.  |  |  |  |  |  |                     |  |   |  |                                   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |                     |  |   |  |                                   |  |
| d.  |  |  |  |  |  |                     |  |   |  |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |                     |  | 24a. WAS AN AUTOPSY PERFORMED?  |  |                                   |  |
|   |  |  |  |  |  |                     |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                     |  |                                   |  |
|   |  |  |  |  |  |                     |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?                                 |  |                                   |  |
|   |  |  |  |  |  |                     |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  |  |  | 26. PLACE OF DEATH (Check only one)  |  |                     |  |   |  |                                   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                     |  |   |  |                                   |  |
| 27. MANNER OF DEATH   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY |  | 28c. INJURY AT WORK?  |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  |  |  | M                   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |                                   |  |
| 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  |  |  |                     |  |   |  |                                   |  |
| 29a. CERTIFIER (Check only one)   |  |  |  | 29c. LICENSE NUMBER  |  |                     |  |   |  |                                   |  |
| 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                   |  |  |  | D 30661  |  |                     |  |   |  |                                   |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |                     |  |   |  |                                   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)  |  |                     |  |   |  |                                   |  |
| Sireesh K. Tripuraneni  |  |  |  | 9/28/90  |  |                     |  |   |  |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  | 31. DATE FILED (Month, Day, Year)  |  |                     |  |   |  |                                   |  |
| SIREESH TRIPURANENI   |  |  |  | OCT 02 1990  |  |                     |  |   |  |                                   |  |
| 32. REGISTRAR'S SIGNATURE   |  |  |  |  |  |                     |  |   |  |                                   |  |
| John Davidson-Randall   |  |  |  |  |  |                     |  |   |  |                                   |  |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. DECEDENT'S NAME (First, Middle, Last)  |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR  |  | 3. TIME OF DEATH<br>HOUR MIN AM/PM   |  |
|---|--|--|---|---|--|--|--|
| CRYSTAL A. FOY  |  |  |   | 09 / 30 / 1990  |  | 14:11 A M  |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>28 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>9-12-1962   | 8. BIRTHPLACE (State or Foreign Country)<br>N.C. |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  | 9c. COUNTY OF DEATH<br>BALTIMORE CITY  |  |
| 10a. STATE<br>Md  |  | 10b. COUNTY  |   | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br>6512 Eberle Drive   |  |  |   | 10f. ZIP CODE<br>21215  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U S A   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)  |   | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John J. Foy  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Joan Swindel   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>John J. Foy   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6512 Eberle Drive Baltimore, Md 21215  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Greenwood Cemetery   |   | 20c. LOCATION — City or Town, State<br>Newbern N. C.  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Dale March</i>  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>March F/H West<br>4300 Wabash Avenue  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cerebral herniation</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>rebleed of subarachnoid hemorrhage</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>giant aneurysm rupture</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |   |   |  | Approximate Interval Between Onset and Death<br>3 days<br>3 days<br>14 days  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |   |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. DATE OF INJURY (Month, Day, Year)<br>9/16/90   |  | 28b. TIME OF INJURY<br>M   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>home   |   | 28e. DESCRIBE HOW INJURY OCCURRED<br>Seizure  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>BALTIMORE   |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>R. Veloso MD</i>  |  |  |   | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/30/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>K. Veloso, MD Johns Hopkins Hospital, Baltimore, MD  |  |  |   |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990  |  |  |   | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |

2 127 1000

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26839

|   |  |   |  |   |   |   |   |  |  |  |
|---|--|---|--|---|---|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Lena Margaret FIKE</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> / DAY <b>28</b> / YEAR <b>90</b>   |   | 3. TIME OF DEATH<br><b>5:50 A M</b>   |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219 58 3636</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>85</b> YRS.  |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>10/11/1904</b>                                 |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>West Virginia</b> |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Franklin Square Hospital</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rossville</b>   |   |   | 9c. COUNTY OF DEATH<br><b>Baltimore County</b>  |  |  |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY<br><b>Balt</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Rosedale</b>  |   |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><b>7921 Oakdale Ave</b>   |  |   |  | 10f. ZIP CODE<br><b>21237</b>   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |   |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                               |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home maker</b> |   |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Silas F. Moyer</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Rosa M. Glover</b>  |   |   |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Genevieve Donelson</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7921 Oakdale Ave Rosedale, MD 21237</b>   |   |   |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Garden of Faith</b>  |  | 20c. LOCATION — City or Town, State<br><b>Balt, MD</b>  |   |   |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>[Signature]</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Catholic Rosedale FH 121 Chesaco Ave 21237</b>   |   |   |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Urinary Tract Infection</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Sepsis secondary to Pneumonia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |   |   | Approximate Interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Parkinson's Disease</b><br><b>Alzheimer's Disease</b><br><b>Lower Gastrointestinal Bleeding</b>  |  |   |  |   |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residencia <input type="checkbox"/> Other (Specify) |  |   |   |   |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED                                |  |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Kenneth Fleishman M.D.</b>  |  | 29c. LICENSE NUMBER<br><b>N/A</b>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/28/90</b>                                       |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Kenneth Fleishman M.D. 9000 Franklin Square Drive Baltimore Maryland 21237</b>  |  |   |  |   |   |   |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |   |   |   |  |  |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |
|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Melvin Lee Fisher</b><br><b>FISHER, MELVIN L.</b>  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>28</b> YEAR <b>90</b>  |   | 3. TIME OF DEATH<br><b>8:30 p<sup>M</sup></b>  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-28-4554</b>   | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>59</b> YRS.   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>02-24-31</b>   |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>VA.</b>   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>CHURCH HOSPITAL CORPORATION</b>  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>   |   | 9c. COUNTY OF DEATH  |
| 10a. STATE<br><b>MD</b>   |  |  | 10b. COUNTY  |   | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |
| 10e. STREET AND NUMBER<br><b>2009 E 31ST street</b>   |  |  | 10f. ZIP CODE<br><b>21218</b>  |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>ARMY</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>  |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b><br>College (1-4 or 5+) <b>BETH. STEEL</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>BETH. STEEL</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>EMERSON WILDER FISHER</b>   |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY JORDAN</b>  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARY FISHER</b>  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2009 E. 31ST.-BALTIMORE, MD. 21218</b> |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST VET. CEM.</b>   |  | 20c. LOCATION — City or Town, State<br><b>OWINGS MILLS, MD.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Portia Ebron</i>  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>metastatic lung cancer</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. <i>COPD</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>d.<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
|   |  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br><i>02/28/90</i>  |  | 28b. TIME OF INJURY<br><b>M</b>   |  |
|   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURED  |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Eugene Choron, MD</i>   |  |  | 29c. LICENSE NUMBER<br><b>D38757</b>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/28/90</b>  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Eugene Choron, MD / Church Hospital, Balt., MD</i>  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>9/28/1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |  |



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26841

|  |  |   |             |   |   |   |   |  |   |   |  |
|--|--|---|-------------|---|---|---|---|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>Irvin Fraction</u>  |  |   |             | 2. DATE OF DEATH<br>MONTH <u>09</u> DAY <u>26</u> YEAR <u>90</u>  |   | 3. TIME OF DEATH<br><u>9:10 AM</u>                        |   |  |   |   |  |
| 4. SOCIAL SECURITY NUMBER<br><u>214-26-2538</u>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |             | 6. AGE (In yrs. last birthday)<br><u>59</u> YRS.  |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>12-13-32</u> |   | 8. BIRTHPLACE (State or Foreign Country)<br><u>MD</u>                                      |   |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>Bun Securus Hosp</u>  |  |   |             | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Baltimore</u>   |   |   |   | 9c. COUNTY OF DEATH  |   |   |  |
| RESIDENCE OF DECEDENT  |  |   |             |   |   |   |   |  |   |   |  |
| 10a. STATE<br><u>MARYLAND</u>  |  |   | 10b. COUNTY |   |   | 10c. CITY, TOWN OR LOCATION<br><u>BALTIMORE CITY</u>      |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br><u>1638 N. MONROE STREET</u>   |  |   |             |   | 10f. ZIP CODE<br><u>21217</u>   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                             |  |   |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><u>9/3/50 - 4/30/52</u> |             | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |   |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>BLACK</u> |  |   |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  |   |             | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)   |   |   | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>ALBERT FRACTION</u>  |  |   |             |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>PEARL STEWARD</u> |   |   |  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>IRVINETTE KOSH</u>  |  |   |             | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>1638 N. Monroe St., Balto, MD 21217</u>   |   |   |   |  |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Garrison Forest Cemetery</u>   |             |   | 20c. LOCATION — City or Town, State<br><u>Owings Mill, Maryland</u>       |   |   |  |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>Leroy O. Dyett</u>   |  |   |             | 22. NAME AND ADDRESS OF FACILITY<br><u>Leroy O. Dyett &amp; Son Funeral Home</u><br><u>4600 Liberty Heights Avenue 21207</u>  |   |   |   |  |   |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <u>Anoxic Encephalopathy 2° to Cardiopulmonary arrest</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>Respiratory failure</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u>Pneumonia</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <u>Seizure</u><br>Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |             |   |   |   |   | Approximate Interval Between Onset and Death   |   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |             |   |   |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |             | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |   |  |   |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  |   |             | 28a. DATE OF INJURY (Month, Day, Year)<br><u>N/A</u>  |   | 28b. TIME OF INJURY<br><u>M</u>                           |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO           |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |             | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>A. Mathew M.D.</u>  |   |   |   | 29c. LICENSE NUMBER<br><u>D27716</u>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><u>9-26-90</u>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>Alyamara J. Mathew 5411 Old Frederick Rd. Catonsville MD 21229</u>   |  |   |             |   |   |   |   |  |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><u>OCT 02 1990</u>  |  |   |             | 32. REGISTRAR'S SIGNATURE<br><u>Julia Davidson-Randall</u>  |   |   |   |  |   |   |  |

1000 08



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26842

|   |  |   |  |   |  |  |                                  |   |  |  |  |
|---|--|---|--|---|--|--|----------------------------------|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Dorothy H. Graybeal   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 28 1990   |  | 3. TIME OF DEATH<br>11:30 P. M.  |                                  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>292-18-4134  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>67 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Sept. 15, 1923                             |                                  | 8. BIRTHPLACE (State or Foreign Country)<br>Ohio  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>302 E. Joppa Road   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Towson   |  |  | 9c. COUNTY OF DEATH<br>Baltimore |   |  |  |  |
| 10a. STATE<br>Maryland  |  |   |  | 10b. COUNTY<br>Baltimore  |  | 10c. CITY, TOWN OR LOCATION<br>Towson  |                                  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br>302 E. Joppa Road   |  |   |  | 10f. ZIP CODE<br>21204  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |                                  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES:   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |                                  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12<br>College (1-4 or 5+) 1   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Owner  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Kings Court Motel   |  |  |                                  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Harry E. Henderson   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Virginia Fenton  |  |  |                                  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Wilbert M. Graybeal   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same As #10  |  |  |                                  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Green Mount Crematory 10-1-90   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Maryland  |  |  |                                  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Wallace S. Brooks, Jr.   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Ruck Towson Funeral Home, Inc.<br>1050 York Road, Towson, Md. 21204   |  |  |                                  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Esophageal Carcinoma</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {<br>b. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |   |  |   |  |  |                                  | Approximate Interval Between Onset and Death<br>- 9 months  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>C.S.P.D.</u>   |  |   |  |   |  |  |                                  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |                                  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |                                  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |                                  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Joseph Adams M.D.  |  |   |  | 29c. LICENSE NUMBER<br>D32783   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/29/90                                       |                                  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Joseph Adams M.D. 7401 Osler Drive, Towson, Md. 21204  |  |   |  |   |  |  |                                  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 2 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |                                  |   |  |  |  |

20423. 00

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26843

|  |  |   |  |   |  |   |  |  |  |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>GEORGE EDWARD GRAEFE</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 26, 1990</b>   |  | 3. TIME OF DEATH<br><b>2:41 PM</b>                          |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-36-0257</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>87</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>10/22/1902</b> |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Fallston General Hospital</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Fallston</b>  |  |   | 9c. COUNTY OF DEATH<br><b>Harford</b>                                      |  |  |
| 10a. STATE<br><b>Maryland</b>  |  |   | 10b. COUNTY<br><b>Harford</b>  |   | 10c. CITY, TOWN OR LOCATION<br><b>Joppa</b>                      |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>911 Mountain Road</b>   |  |   |  | 10f. ZIP CODE<br><b>21085</b>   |  |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                             |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b> |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3</b><br>College (1-4 or 8+) <b>--</b>  |  |   | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Farmer</b> |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Farming</b>            |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Frederick Edward Graefe</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lena Lintz</b>  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Earl Graefe</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>21074<br/>4540 Black Rock Road Hampstead, Md.</b>   |  |   |  |  |  |
| 20. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Jarrettsville Cemetery</b>   |  |   | 20c. LOCATION — City or Town, State<br><b>Jarrettsville, Md.</b> |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>M. Gladden Kurtz</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Kurtz Funeral Home<br/>Jarrettsville, Md. 21084</b>  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MASSIVE MYOCARDIAL INFARCTION</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>CORONARY ARTERY DISEASE</b><br><br><b>AORTIC STENOSIS</b><br><b>AORTIC INSUFFICIENCY</b> |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>minutes</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>AORTIC STENOSIS</b><br><b>AORTIC INSUFFICIENCY</b>  |  |   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |  |   |  | 28. DESCRIBE HOW INJURY OCCURRED   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Kurtz</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D38457</b>   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>9-26-90</b>  |  |   |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>N. GOYAL, MD; FALLSTON GENERAL HOSPITAL, FALLSTON, MD</b>   |  |   |  | 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>  |  |
| 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Rendell</b>   |  |   |  |   |  |   |  |  |  |



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26844

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>William M. Guizzardi</i>  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>9 29 90</i>   |  | 3. TIME OF DEATH<br><i>1:15 A.M.</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>219 01 8933</i>  |  | 5. SEX<br><i>1</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>75</i> YRS.  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>7 13 15</i>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i>  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Harbor Hosp.</i>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Balt Md</i>  |  | 9c. COUNTY OF DEATH<br><i>=====</i>   |  |
| 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Anne Arundel</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Baltimore</i>   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><i>5302 Brookwood Road</i>   |  | 10f. ZIP CODE<br><i>21225</i>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>World War II</i> |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><i>Elementary/Secondary (9-12)</i><br><i>10th Grade</i>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Route Salesman</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Cloverland Dairy</i>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Louis J. Guizzardi</i>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Catherine Lyston</i>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Margaret Guizzardi</i>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>5302 Brookwood Road Baltimore, Maryland 21225</i>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Metro Crematory, Inc.</i>   |  | 20c. LOCATION — City or Town, State<br><i>Baltimore, Maryland</i>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>George J. Gonce</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>George J. Gonce Funeral Home P.A.<br/>4001 Ritchie Hwy. Baltimore, Md. 21225</i>  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><i>Chronic Pulmonary Edema</i><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>Heart fail</i><br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  | Approximate Interval Between Onset and Death   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>A.F.B.</i><br><i>Hyper K<sup>+</sup></i><br><i>renal fail</i><br><i>Anemia</i>  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Ben K. ... M.D.</i>  |  | 29c. LICENSE NUMBER   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><i>9/29/90</i>  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>3001 S. Hanover St. Balt Md. 21230</i>   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>OCT 2 - 1990</i>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |  |



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26845

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>John T. Gorsuch, Jr.   |  |   |  | 2. DATE OF DEATH<br>MONTH 9 DAY 29 YEAR 90  |  | 3. TIME OF DEATH<br>5:55 A M  |  |
| 4. SOCIAL SECURITY NUMBER<br>213-36-3297   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 8. AGE (In yrs. last birthday)<br>50 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>02 07 40   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>3220 Clifftmont Ave.   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  |   |  | 9c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Baltimore  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>3220 Clifftmont Avenue   |  |   |  | 10f. ZIP CODE<br>21213  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Chemist   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>State Govt.   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John T. Gorsuch, Sr.  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Margaret Mary League   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>John T. Gorsuch, 3rd   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2949 Bero Road, Lansdowne, Maryland 21227  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Glen Haven Cemetery   |  | 20c. LOCATION — City or Town, State<br>Glen Burnie, Maryland  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Ambrose Funeral Home, Inc.<br>1328 Sulphur Spring Rd., Arbutus, Md. 21227   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |   |  |   | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |   |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.  |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Diabetes Mellitus  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |   |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/29/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ann M. Dixon, M.D. 111 Penn St. Baltimore, Md. 21201  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 2 1990  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-8146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

100-100-100

17

4

1.4

2

3

1

1

2

1

2

1

2

3

100-100-100

100-100-100

1

2




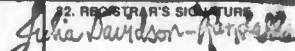
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 90 26846  |
|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Lena D Hartman</b>  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>26</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>1:29 pm</b>   |
| 4. SOCIAL SECURITY NUMBER<br><b>217-01-6607 B</b>  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>91</b> YRS.   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>4-8-99</b> | 8. BIRTHPLACE (State or Foreign Country)<br><b>Germany</b>   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>University Shock trauma</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore City</b>   |
| 10a. STATE<br><b>Md</b>  | 10b. COUNTY<br><b>Baltimore City</b>   | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |
| 10e. STREET AND NUMBER<br><b>2411 Chesterfield ave</b>   |  | 10f. ZIP CODE<br><b>21213</b>  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>       |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Jr. High</b><br>College (1-4 or 5+) <b>Vocational</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Seamstress</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Hutzlers</b>  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Unknown Geschwendt</b>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Unknown</b>  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Holly Haupt</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3921 Carthage Road Randallstown, MD 21133</b>  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Moreland Memorial Park</b>  |  | 20c. LOCATION — City or Town, State<br><b>Parkville, Maryland</b>  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Stephen M Gentile</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Road Randallstown, MD 21133</b>   |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Cerebral edema</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. <b>subdural hematoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
|  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   | 28b. TIME OF INJURY<br><b>M</b>                      | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>A. Chatillon</i>   |  | 29c. LICENSE NUMBER  |
|  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>26/9/90</b>  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>A. CHATILLON - SHOCK TRAUMA - ANNU.</b>  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |  |



**DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146**

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Catherine A. Hildebrand</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>09</b> - DAY <b>30</b> - YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>5:25 P.M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-24-1743</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 6. AGE (in yrs. last birthday)<br><b>61</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11-25-28</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Stella Maris Hospice</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| 10a. STATE<br><b>MD.</b>   |  |   |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>1326 Halstead Road</b>   |  |   |  |
| 10f. ZIP CODE<br><b>21234</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Customer Service</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Best Products</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Robert M. Martin</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Katherine Watkins</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Donald E. Hildebrand</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1326 Halstead rd. Balto. Md.-21234</b>  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Balto. Md.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>6415 Belair Road<br/>John C. Miller, Inc. Baltimore, Md.-21206</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>glioblastoma</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Carla S. Alexander, M.D.</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>D 27087</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>09-30-90</b>                                      |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Carla S. Alexander, M.D. - Stella Maris Hospice-Dulaney Valley Rd.-Towson 21204</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |  |



90 26848

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |   |   |
|---|--|--|--|---|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Jeannette Linda Harvard</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 29 90</b>   |  | 3. TIME OF DEATH<br><b>11:25pm</b>  |   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>212-48-9780</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>44</b> YRS. |   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>01-04-46</b> |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Springfield State Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Sykesville</b>  |  | 9c. COUNTY OF DEATH<br><b>Carroll</b>   |   |   |
| 10a. STATE<br><b>MARYLAND</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |   |
| 10e. STREET AND NUMBER<br><b>804 WILDWOOD PARKWAY</b>   |  |  |  | 10f. ZIP CODE<br><b>21229</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U. S. OF A.</b>   |   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                             |   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0-12</b><br>College (1-4 or 5+) <b></b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>MEDICAL RECORDS CLERK</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>HOSPITAL</b>   |  |   |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Kayes</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jeannette Marshall</b>  |  |   |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MRS. GERALDINE JONES</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>804 WILDWOOD PARKWAY BALTIMORE, MARYLAND 21229</b>  |  |   |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ARBUTUS MEMORIAL PARK 10/4/90</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD. BALTO.CO.</b>  |  |   |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Lewis T Gwynn</b>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEWIS T GWYNN Funeral Home<br/>4517 Park Heights Ave. Balto., MD 21215</b>  |  |   |  |   |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Tumoral Cachexia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>Disseminated Metastases</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Carcinoma Rt Kidney</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate Interval Between Onset and Death<br><b>3y.</b> |  |  |  |   |  |   |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br><br><br>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <b></b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   | 28d. DESCRIBE HOW INJURY OCCURRED   |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Alejandro Mejia MD</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D08780</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>092990</b>  |   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ALEJANDRO MEJIA MD</b>  |  |  |  |   |  |   |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randell</b>   |  |   |  |   |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 5 should be detached for use as a transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |   |  |   |  |  |  | 90 26849  |  |   |  |
|--|--|---|--|---|--|---|--|--|--|---|--|---|--|
| 1 - FOR STATE REGISTRAR  |  |   |  |   |  |   |  |  |  | REG. NO.  |  |   |  |
| CERTIFICATE OF DEATH   |  |   |  |   |  |   |  |  |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Francis Albert HASSAY  |  |   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>September 28, 1990  |  | 3. TIME OF DEATH<br>8:55 a.m.  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>201 24 6283   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>58 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>6/3/32  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Pennsylvania                             |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Franklin Square Hospital   |  |   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Rossville  |  | 9c. COUNTY OF DEATH<br>Baltimore, Md Co.   |  |   |  |   |  |
| 10a. STATE<br>Md   |  | 10b. COUNTY<br>Balto  |  | 10c. CITY, TOWN OR LOCATION<br>Rosedale   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |  |   |  |   |  |
| 10e. STREET AND NUMBER<br>8051 Woodhaven Rd  |  |   |  | 10f. ZIP CODE<br>21237  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>Korean |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |  |  |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+) /  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Postal worker T-6  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Post Office   |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Andrew Hassay   |  |   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary PETROS                                    |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Helen A. Hassay  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8051 Woodhaven Rd Rosedale Md 21237  |  |   |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Garden of Faith   |  | 20c. LOCATION — City or Town, State<br>Balto, Md.   |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>CvACH/Rosedale FA 1211 Chesapeake Ave 21237   |  |   |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Myocardial Infarction<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF): Atherosclerotic Cardiovascular Disease<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Deep Second Degree Burns of Chest and Right Arm<br>Possible Aspiration Pneumonitis   |  |   |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> ODA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |   |  | 29c. LICENSE NUMBER<br>N/A   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/28/90  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>M. L. Frydenborg, Md 9000 Franklin Square Drive, Baltimore, Md 21237  |  |   |  |   |  |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |  |  |   |  |   |  |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26850

|   |  |  |  |   |  |   |  |   |   |   |  |
|---|--|--|--|---|--|---|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) (ANNA V. HAYES)<br>Annie VIOLA Hayes   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>September 26, 1990  |  | 3. TIME OF DEATH<br>2:30AM  |  |   |   |   |  |
| 4. SOCIAL SECURITY NUMBER<br>214-12-2948  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>86 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>11-30-03                                    |  | 8. BIRTHPLACE (State or Foreign Country)<br>VA.   |   |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Maryland General Hospital   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  |   | 9c. COUNTY OF DEATH  |   |   |   |  |
| 10a. STATE<br>MD  |  |  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE, CITY  |  |   | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br>5812 BELLE GROVE RD.  |  |  |  | 10f. ZIP CODE<br>21225  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |   |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK |   |   |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) 9th College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>HOUSEWIFE  |  |   | 16b. KIND OF BUSINESS/INDUSTRY                                   |   |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>ROBERT BROWN   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>HOLLY ANN HARPER   |  |   |  |   |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>CHRISTIAN NINS  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1760 LINCOLN AVE.-ST. PAUL PK. MINN. 55071   |  |   |  |   |   |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>KING MEMORIAL PARK  |  |   | 20c. LOCATION — City or Town, State<br>RANDALLSTOWN, MD.         |   |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Gladys Warner  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>WM.C. MARCH F.H. 1101 E. NORTH AVE.   |  |   |  |   |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis<br>DUE TO (OR AS A CONSEQUENCE OF): Methicillin resistant Staphylococcus aureus.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. Methicillin resistant Staphylococcus aureus<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death<br>9/3-9/26  |   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
|   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                              |   |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |   |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>B. Sailkaly M.D.   |  |  |  |   |  | 29c. LICENSE NUMBER<br>N/A  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/26/90  |   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Bashar Sailkaly, M.D. c/o Maryland General Hospital  |  |  |  |   |  |   |  |   |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Jill Davidson-Randall  |  |   |  |   |   |   |  |



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 90 26851

|  |  |  |   |   |  |  |  |   |   |   |
|--|--|--|---|---|--|--|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Dorothy Hedeman  |  |  |   |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09/30/90                                       |  | 3. TIME OF DEATH<br>M   |   |   |
| 4. SOCIAL SECURITY NUMBER<br>216-03-1890   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |   | 6. AGE (In yrs. last birthday)<br>76 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>06/06/14                                      |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>St. Agnes CPER   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  |  |  | 9c. COUNTY OF DEATH   |   |   |
| 10a. STATE<br>Maryland   |  |  | 10b. COUNTY<br>Baltimore  |   | 10c. CITY, TOWN OR LOCATION<br>Arbutus                     |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |   |
| 10e. STREET AND NUMBER<br>408 Gun Road   |  |  |   | 10f. ZIP CODE<br>21227  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |  |   |   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 0-12<br>College (1-4 or 5+) -----   |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>clerk |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>mfg.   |  |   |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Harry Patterson   |  |  |   |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Annie Velten                    |  |   |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Harold E. Hedeman  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>408 Gun Road Arbutus, Maryland 21227   |  |  |  |   |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Loudon Park Cemetery   |   |   | 20c. LOCATION — City or Town, State<br>Baltimore City, Md. |  |  |   |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Ambrose Funeral Home, Inc.<br>1328 Sulphur Spring Road 21227  |  |  |  |   |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Atherosclerotic Cardiovascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |   |   |  |  |  |   | Approximate Interval Between Onset and Death  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Lumbar laminectomy (Surgery) performed for Spinal Stenosis Sept. 20, 1990  |  |  |   |   |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |   |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |   |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |   |   |
| 29a. CERTIFIER (Specify only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |   |  |  |  |   |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |   | 29c. LICENSE NUMBER<br>V08412   |  | 29d. DATE SIGNED (Month, Day, Year)<br>Oct 1, 1990                                   |  |   |   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Edward D. WAYNE MD, 3449 WILKENS AVE, Balt. Md. 21229   |  |  |   |   |  |  |  |   |   |   |
| 31. DATE FILED (Month, Day, Year)<br>OCT 2 1990  |  | 32. REGISTRAR'S SIGNATURE<br>  |   |   |  |  |  |   |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15 12 15

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

90 26852

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>E. CATHERINE HOWARD</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> - DAY <b>28</b> - YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>10:50P</b> M  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>214-03-7878-A</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 8. AGE (In yrs. last birthday)<br><b>80</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12-13-90</b>                               |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>MERCY MEDICAL CENTER</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH  |   |
| 10a. STATE<br><b>MD.</b>  |  |  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                                      |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |  |   |
| 10e. STREET AND NUMBER<br><b>616 EAST 35<sup>th</sup>. STREET</b>   |  |  |  | 10f. ZIP CODE<br><b>21218</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                       |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>           |   |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>  |  | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>OPERATOR</b>                    |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>E. COPLAN CO.</b>  |  |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>SAMUEL EMORY HOWARD</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SADIE COURSEY</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>PETER P. BROZOWSKI</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>105 S. POTOMIC ST. BALTIMORE, MD. 21224</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MOUNT OLIVET CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD. 21223</b>  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>R. G. Ruth</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>HENRY W. JENKINS AND SONS<br/>4905 YORK RD. BALTO. MD. 21212</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardio pulmonary arrest.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>brainstem CVA</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>1 day</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |   |
| 29. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29a. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>D35674</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-29-90</b>                                |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>WANDA J. SIMMONS-CLEMMONS M.D. 5444 BELAIR RD. BALTO. MD. 21206</b>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 2 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>J. Davidson-Randall</i>  |  |   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26853

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Lionne Turner Jenkins</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 28, 1990</b>   |  | 3. TIME OF DEATH<br><b>12:10 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-10-0578D</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>94</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>12/18/95</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Meridian Nursing Center</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Catonsville</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Anne Arundel</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Pasadena</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>405 Edgewater Road</b>  |  |   |  | 10f. ZIP CODE<br><b>21122</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>8th</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Home</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Monroe Turner</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>"Unknown to Records". Hyatt</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Edmund E. Jenkins</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>405 Edgewater Rd. Pasadena, MD 21122</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Lorraine Park Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Woodlawn, MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><br><b>George E. MacNabb</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MacNabb Funeral Home, P.A.<br/>301 Frederick Rd. Balto., MD 21228</b>  |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. Dehydration, Renal Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. ASCVD w/atrial Fibrillation. CVA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 29. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>John H. Shaw, M.D.</b>  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>09/28/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>John H. Shaw, M.D. 5800 Edmondson Ave. Baltimore, MD 21228</b>   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the funeral permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

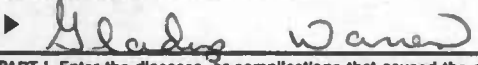
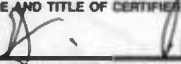
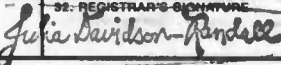
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26854

|  |  |   |  |   |   |   |   |   |   |  |
|--|--|---|--|---|---|---|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>LEROY JACKSON</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>25</b> YEAR <b>90</b>   |   | 3. TIME OF DEATH<br><b>M</b>  |   |   |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-30-6336</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.  |   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9-07-27</b>                                       |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>VA.</b>  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>JOHN HOPKINS HOSPITAL</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |   |   |   | 9c. COUNTY OF DEATH   |   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE, CITY</b>   |   |   |   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br><b>422 E. 23rd STREET</b>  |  |   |  | 10f. ZIP CODE<br><b>21218</b>   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |   |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>ARMY</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |   |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                            |   |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7th</b><br>College (1-4 or 5+) <b>BETH. STEEL</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>BETH. STEEL</b>   |  |   |   | 16b. KIND OF BUSINESS/INDUSTRY  |   |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN M. JACKSON</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>GERTRUDE HURT</b>   |   |   |   |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>OLA MAE JACKSON</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>422 E. 23rd ST.-BALTIMORE, MD. 21218</b>  |   |   |   |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST VET. CEM.</b>  |  |   | 20c. LOCATION — City or Town, State<br><b>OWINGS MILLS, MD.</b> |   |   |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C. MARCH F.H. 1101 E. NORTH AVENUE 21202</b>  |   |   |   |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hypertension</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Diabetes Mellitus</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>Due to (or as a consequence of):</b><br><br><b>Due to (or as a consequence of):</b><br><br><b>Due to (or as a consequence of):</b> |  |   |  |   |   |   | Approximate Interval Between Onset and Death  |   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospital</b> |  |   |   |   |   |   |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |   |   |   |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |   |   |   |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |   |  | 29c. LICENSE NUMBER<br><b>DR-3621</b>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-28-90</b>                                       |   |   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Alphonso Y.S. Rhee, MD 449 E. 25th Street</b>  |  |   |  |   |   |   |   |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 9 28 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>  |   |   |   |   |   |  |



ITEM:1 per FH G-668

10-3-90 cm

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26855

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Blanche Kimbro KIMBROW</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>27</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>6:24P</b> M  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>216-36-0706</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>52</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12/2/38</b>   |   |
| 8a. FACILITY NAME (If not institution, give street and number)<br><b>5518 Wayne Avenue (Residence)</b>   |  |   |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 8c. COUNTY OF DEATH<br><b>KENTUCKY</b>  |   |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>5518 Wayne Avenue</b>   |  |   |  | 10f. ZIP CODE<br><b>21207</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                         |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WILLIAM C. KIMBROW, SR.</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ETHEL RILEY</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Nettie Kimbro</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5518 Wayne Avenue, Baltimore, MD 21207</b>  |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>WOODLAWN CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>WOODLAWN, MARYLAND</b>  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Leroy O. Dyett</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leroy O. Dyett &amp; Son Funeral Home<br/>4600 Liberty Heights Avenue 21207</b>  |  |   |  |   |   |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Mutastatic Breast Carcinoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br><b>4yrs</b>   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |   |  |   |   |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Marshall A. Yum</i>  |  |   |  | 29c. LICENSE NUMBER<br><b>D17873</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/28/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>4000 Old Court Rd Baltimore, MD 21208</b>  |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson</i>  |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

24 50 00

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be submitted for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26856

|  |  |   |  |   |  |   |                     |  |  |
|--|--|---|--|---|--|---|---------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Ellen J. Knight  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9 29 90   |  | 3. TIME OF DEATH<br>M   |                     |  |  |
| 4. SOCIAL SECURITY NUMBER<br>212-09-7436   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>75 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>8-30-15  |                     | 8. BIRTHPLACE (State or Foreign Country)<br>Md.  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Key Medical Center   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Balto.   |  |   | 9c. COUNTY OF DEATH |  |  |
| 10a. STATE<br>Md.  |  |   |  | 10b. COUNTY<br>Balto.   |  | 10c. CITY, TOWN OR LOCATION   |                     | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>8227 Dundalk Ave.  |  |   |  | 10f. ZIP CODE<br>21224  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |                     |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |                     |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>10   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Office  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Cross & Blackwell   |  |   |                     |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John H. Norfolk   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Eva Jones  |  |   |                     |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Joan E. Popp   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8353 Boca Rio Dr. Boca Raton FL. 33433   |  |   |                     |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Bel Air Mem. Gardens  |  | 20c. LOCATION — City or Town, State<br>Bel Air, Md.   |  |   |                     |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>John C. Miller Inc.<br>6415 Belair Rd. Balto., Md. 21206  |  |   |                     |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC LUNG CANCER<br>Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br>1 yr |  |   |  |   |  |   |                     |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                     | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |                     |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO           |                     | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                              |                     |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |                     |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |   |  |   |  | 29c. LICENSE NUMBER<br>DIS808   |                     | 29d. DATE SIGNED (Month, Day, Year)<br>10/1/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>WILLIAM E RANDALL JR, Suite 33, 1205 York Rd Luthermar, 21547   |  |   |  |   |  |   |                     |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |                     |  |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26857

|   |  |  |  |   |   |  |   |  |  |   |  |  |  |
|---|--|--|--|---|---|--|---|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Goldie B. Longley   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>10-1-1990   |   | 3. TIME OF DEATH<br>5:30 P.M.  |   |  |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>219-30-7653  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>YRS. MONTHS DAYS<br>90  |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>12-15-1899                                 |   | 8. BIRTHPLACE (State or Foreign Country)<br>Russia   |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Meridian Nursing Center   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Randallstown   |   |  | 9c. COUNTY OF DEATH<br>Baltimore County   |  |  |   |  |  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |   |  |   |  |  |   |  |  |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Baltimore County  |  | 10c. CITY, TOWN OR LOCATION<br>Randallstown   |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>9109 Liberty Rd.  |  |  |  | 10f. ZIP CODE<br>21133  |   | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |   |  |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>Unknown  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Nurse   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>GBMC  |   |  |   |  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Unknown Bordansky  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Unknown  |   |  |   |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. Edward Longley  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4217 Queen Mary Dr. Olney, MD 20832  |   |  |   |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Lorraine Park Cemetery   |  |   | 20c. LOCATION — City or Town, State<br>Woodlawn, MD |  |   |  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>John K. Agnew  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Loring Byers Funeral Directors, Inc.<br>8728 Liberty Rd. Randallstown, MD 21133   |   |  |   |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Arteriosclerosis</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b.<br>c.<br>d.<br>Approximate Interval Between Onset and Death |  |  |  |   |   |  |   |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Hypertension</u><br><u>Anemia</u>  |  |  |  |   |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |  |   |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |   |  |   | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Jerome H. Ginsberg M.D.                               |  | 29c. LICENSE NUMBER<br>D20964   |  | 29d. DATE SIGNED (Month, Day, Year)<br>10-2-90 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Jerome H. Ginsberg, M.D.; 8630 Liberty Plaza Mall; Randallstown, Md. 21133   |  |  |  |   |   |  |   |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990  |  |  |  |   |   |  |   | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |  |  |  |

76002

02

10

1968-1970



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detachable and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26858

|   |  |  |  |  |  |  |  |   |  |   |  |   |  |   |  |
|---|--|--|--|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>E. LeRoy Longley  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>September 29, 90   |  |  |  | 3. TIME OF DEATH<br>M   |  |   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>216-22-0869  |  | 6. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 8. AGE (In yrs. last birthday)<br>94 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>2-12-96 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Meridian Nursing Home   |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Randallstown  |  |   |  | 9c. COUNTY OF DEATH<br>Baltimore                  |  |   |  |   |  |
| 10a. STATE<br>Maryland  |  |  |  | 10b. COUNTY<br>Baltimore   |  |  |  | 10c. CITY, TOWN OR LOCATION<br>Randallstown   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |
| 10e. STREET AND NUMBER<br>9109 Liberty Road   |  |  |  |  |  | 10f. ZIP CODE<br>21133   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.           |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW I   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>5 Years  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Teacher   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Poly High School  |  |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Thomas Edward Longley  |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Grace Ella Blanche Zimmerman  |  |   |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. Edward Longley  |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4217 Queen Mary Drive Olney, MD 20832 |  |   |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Lorraine Park Cemetery   |  |  |  | 20c. LOCATION — City or Town, State<br>Woodlawn, MD   |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>John K. Arnold Jr.   |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Loring Byers Funeral Directors, Inc.<br>8728 Liberty Road Randallstown, MD 21133                   |  |   |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>arteriosclerosis</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Hypertension</u>   |  |  |  |  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO      |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED                 |  |   |  |   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Joe O. M.D.  |  |  |  |  |  |  |  | 29c. LICENSE NUMBER<br>D20964   |  | 29d. DATE SIGNED (Month, Day, Year)<br>10-1-90    |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Jerome Ginsberg; 8630 Liberty Plaza Mall; Randallstown, Md. 21133  |  |  |  |  |  |  |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |  |   |  |   |  |   |  |   |  |



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 90 26859

FOR  
STATE  
REGISTRAR

15+1

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Vincent A. Libertini  |  |   |  | 2. DATE OF DEATH<br>MONTH 9 DAY 28 YEAR 90  |  | 3. TIME OF DEATH<br>M   |  |
| 4. SOCIAL SECURITY NUMBER<br>217-01-6515  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>73 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>9-24-17   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Md.   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>3003 Pelham Avenue  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore  |  |
| 9c. COUNTY OF DEATH   |  |   |  |   |  |   |  |
| 10a. STATE<br>Md.   |  |   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br>Balto.   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |   |  |   |  |
| 10e. STREET AND NUMBER<br>3003 Pelham Avenue  |  |   |  | 10f. ZIP CODE<br>21213  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>W.W. II   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Presser  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Haas Tailoring  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Luigi Libertini  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Isabell Fulco  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>John V. Libertini   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3003 Pelham Ave. Balto., Md. 21213   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Gardens of Faith  |  | 20c. LOCATION — City or Town, State<br>Balto., Md.  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Karen H. Murphy</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>6415 Belair Road<br>John C. Miller, Inc. Baltimore, Md.-21206   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → CORONARY ARTERY DISEASE<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. ATHEROSCLEROSIS<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DIABETES MELLITUS.  |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>A.H. Ghiladi, MD.</i>   |  |   |  | 29c. LICENSE NUMBER<br>D-12849.   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-28-90.   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>A.H. GHILADI, MD. 7600 OSLER Dr. Towson MD 21204   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 5 should be detached for the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26860

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>James M. Lyons   |  |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 29 YEAR 90  |  | 3. TIME OF DEATH<br>7:30 A M  |  |
| 4. SOCIAL SECURITY NUMBER<br>216-78-8663   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>20 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>7-7-70   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>MD   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>University Hospital Shock Trauma   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br>MD   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>2715 Giles Rd  |  |  |  | 10f. ZIP CODE<br>21225  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>Army Reserves  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Military  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>James A. Lyons  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Matilda Mae Brown  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Matilda Adger  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2715 Giles Rd, Balto., MD. 21225   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Garrison Forest  |  | 20c. LOCATION — City or Town, State<br>Owings Mills, MD   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Charles D. Brown  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Joseph H. Brown F.F. P.O. Box 4433<br>Balto., MD 21223  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Closed Head Injury<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>INSPECTION                                |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)<br>9/28/90   |  | 28b. TIME OF INJURY<br>3:55P M  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>Pedestrian struck by auto   |  | 29a. CERTIFIER<br>(Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Ann M. Dixon, M.D.  |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/30/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ann M. Dixon, M.D. 111 Penn St. Baltimore, Md. 21201  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-8146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital and the attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



REG NO

DHMH-18 Rev 1/89





0-1-E

90 26862

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Viola Lee</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>9 24 90</i>  |  | 3. TIME OF DEATH<br><i>1250 p.m.</i>   |   |
| 4. SOCIAL SECURITY NUMBER<br><i>213-10-9066</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>85</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>12-20-04</i>   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>FRANCIS SCOTT KEY</i>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>BALTIMORE, MD.</i>  |  | 9c. COUNTY OF DEATH  |   |
| 10a. STATE<br><i>MD</i>  |  |  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><i>BALTIMORE, CITY</i>  |   |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><i>1808 RUTLAND AVE.</i>  |  | 10f. ZIP CODE<br><i>21213</i>  |   |
| 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  |  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |   |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>BLACK</i>  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>9th</i> College (1-4 or 5+) <i>DISABLED</i>  |   |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>DISABLED</i>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  | 17. FATHER'S NAME (First, Middle, Last)<br><i>JACK JONES</i>   |   |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>EMMA JONES</i>   |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br><i>MANUEL GREEN</i>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2329 GUILFORD AVE.-BALTIMORE, MD 21218</i> |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>MT. CALVARY CEMETERY</i>   |  | 20c. LOCATION — City or Town, State<br><i>ANNE ARUNDEL CO, MD.</i>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Theresa Load</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>WM.C. MARCH F.H. 1101 E. NORTH AVE.</i>  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Renal failure</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>Hypertension</i><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  | Approximate interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Dementia, Hx of coronary artery disease</i>   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO  |   |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Susan Denman MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>D23584</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9/24/90</i>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Susan Denman MD 5200 Eastern Ave Baltimore 21229</i>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><i>OCT 02 1990</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

57



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26863

|  |  |  |  |  |   |   |  |
|--|--|--|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SARAH FRANCIS LEWIS</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 24 90</b>   |   | 3. TIME OF DEATH<br><b>1254A</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-30-0343</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>10-17-09</b>  | 8. BIRTHPLACE (State or Foreign Country)<br><b>VA</b> |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>JOSEPH RICHMOND HOSPICE<br/>628 N. EUTAW STREET</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTO. 21201</b>   |   | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE, CITY</b>  |   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>11 W. 20th APT. 14H</b>   |  |  |  | 10f. ZIP CODE<br><b>21218</b>  |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5th</b> College (1-4 or 5+) <b>DOMESTIC</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)                                |  | 16b. KIND OF BUSINESS/INDUSTRY   |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>SILAS LEWIS</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MARY GREEN LEWIS</b>   |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MARTHA CHAMBERS</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2142 AIKEN ST.-BALTIMORE, MD. 21218</b>  |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT. CALVARY CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>ANNE ARUNDEL CO, MD</b>  |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Arthur Coad</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>   |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Small Cell Carcinoma of Lung</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>B</b> DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |   | Approximate Interval Between Onset and Death<br><b>3 months</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive Heart Failure</b><br><b>Hypertension</b>   |  |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |   | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Constance J. Meyd MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D 29880</b>  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-24-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Constance J. Meyd MD FSKMC 4940 Eastern Ave Balto Md 21220</b>   |  |  |  |  |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |   |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26864

|  |  |  |  |   |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Vernon L. Moore</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>29</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>8:30</b> P M   |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-30-4748</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>56</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>8-18-34</b>                                    |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>N.C.</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital 900 Canton Ave</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore MD.</b>   |  |   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |  |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Baltimore Co.</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore MD</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><b>4801 Wilmer Ave</b>   |  |  |  | 10f. ZIP CODE<br><b>21215</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>US</b>  |  |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Phil L. Moore</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Sarah Perry</b>   |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Elaine ATLee</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3302 Essex Rd., Balto. 1 MD 21207</b>   |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MEM PK</b>  |  | 20c. LOCATION — City or Town, State<br><b>Randallstown, MD</b>  |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F.H. WEST<br/>4300 Wabash Ave</b>  |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>Cerebral Vascular Accident</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Cardiogenic shock</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>Severe coronary vascular disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b>I.D.M.</b> |  |  |  |   |  |   |  | Approximate interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  |   |  | 29c. LICENSE NUMBER<br><b>D07249</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>29 Sept 90</b>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |  |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  | CERTIFICATE OF DEATH  |  | REG. NO. 90 26865  |  |
|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Anne Marie Matthews (ANNE, ANNA) M. MATTHEWS  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9/30/90   |  | 3. TIME OF DEATH<br>8:30 A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>216-07-6593  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>85 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>June 16, 1905   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>804 Thimbleberry Road   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Essex  |  | 9c. COUNTY OF DEATH<br>Baltimore   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Baltimore  |  | 10c. CITY, TOWN OR LOCATION<br>Essex  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br>804 Thimbleberry Road   |  | 10f. ZIP CODE<br>21237  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) 12 College (1-4 or 5+) 12   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Florist (retired)  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Self Employed   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Francis Bubnis   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Maria Paulavicius  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Ellwood Gurklis   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>804 Thimbleberry Road Essex, Maryland 21237  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Cathedral Cemetery  |  | 20c. LOCATION — City or Town, State<br>Baltimore  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John J. Dippel Jr.</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br>Dippel Funeral Home, Inc.<br>7110 Belair Road Baltimore, MD 21206   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Severe COPD</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  | Approximate Interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>M-D</i>   |  | 29c. LICENSE NUMBER<br>D18487   |  | 29d. DATE SIGNED (Month, Day, Year)<br>10/1/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Myo Thant, M.D. 9101 Franklin Square Drive Baltimore, MD. 21237  |  | 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26866

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Helen Mealy  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9 26 90  |  | 3. TIME OF DEATH<br>M  |  |
| 4. SOCIAL SECURITY NUMBER<br>213-20-7014   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>80 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>10-26-09  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Va.  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>University Hosp.   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Balto.  |  |
| 9c. COUNTY OF DEATH  |  |  |  | 10a. STATE<br>Md.  |  | 10b. COUNTY<br>Baltimore   |  |
| 10c. CITY, TOWN OR LOCATION<br>Woodlawn  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>2741 Scarborough Circle  |  |
| 10f. ZIP CODE<br>21207   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>Usa   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: Black   |  |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Thomas Jones  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Emie Jones  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Jeanette Short   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2741 Scarborough Circle Balto, Md 21207   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Western Star Cem   |  |  |  |
| 20c. LOCATION — City or Town, State<br>Catonville, Md  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Dola March  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br>4306 Hawthorne Ave.  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. CONGESTIVE HEART FAILURE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>28b. TIME OF INJURY<br>M<br>28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>28d. DESCRIBE HOW INJURY OCCURRED<br>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>29c. LICENSE NUMBER<br>D24089<br>29d. DATE SIGNED (Month, Day, Year)<br>10/1/90   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>A. OSEI-WUSUMU 5710 WABASH AVE BART-MD 21215  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>10/1/1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26867

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|   |  |  |  |  |  |  |   |
|---|--|--|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>George MICHAEL  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>September 27, 1990   |  | 3. TIME OF DEATH<br>6:16P M  |   |
| 4. SOCIAL SECURITY NUMBER<br>218-26-2045  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>58 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Sept. 22, 1932  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Franklin Square Hospital   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Rossville   |   |
| 9c. COUNTY OF DEATH<br>Baltimore County   |  |  |  | 10a. STATE<br>Md.  |  | 10b. COUNTY<br>BALTIMORE   |   |
| 10c. CITY, TOWN OR LOCATION<br>Essex  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>351 Wye Road   |   |
| 10f. ZIP CODE<br>21221  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th College (1-4 or 5+) College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Machinist  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Western Electric   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>John W. Michael  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Ida Kurts   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Sharon Michael  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>351 Wye Road Baltimore MARYLAND 21221   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Metro Crematory Inc.   |  | 20c. LOCATION — City or Town, State<br>Baltimore Maryland  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Connelly Funeral Home</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>ConnellyFuneralHome300MAceAve. 21221   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Ischemic heart disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Etoh  |  |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Marc Leffer M.D.</i>  |  |  |  | 29c. LICENSE NUMBER<br>D36538  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/27/90   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Marc Leffer, M.D. 9000 Franklin Square Drive- 21237  |  |  |  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |   |



90-5474  
ITEM:2 per ME G-669  
11/16/90 cm

1 FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26868

|  |  |  |  |  |  |   |                             |   |  |  |  |
|--|--|--|--|--|--|---|-----------------------------|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Richard Calvin Mitchell  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9 28 90  |  | 3. TIME OF DEATH<br>7:00 A M  |                             |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>213-98-0343   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>23 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Sept. 22, 1967  |                             | 8. BIRTHPLACE (State or Foreign Country)<br>Md.   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>University Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City  |  |   | 9c. COUNTY OF DEATH<br>City |   |  |  |  |
| 10a. STATE<br>Md.  |  |  |  | 10b. COUNTY<br>Baltimore   |  | 10c. CITY, TOWN OR LOCATION<br>Parkville  |                             | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br>7902 Highpoint Road  |  |  |  | 10f. ZIP CODE<br>21234   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |                             |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>X  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:<br>X |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                             |                             |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Construction Worker   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |                             |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Calvin W. Mitchell  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Grace E. Johnson  |  |   |                             |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Calvin W. Mitchell   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7902 Highpoint Rd. 21234 Baltimore, Maryland  |  |   |                             |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Dulaney Valley Mem. Oct. 3, 1990   |  | 20c. LOCATION — City or Town, State<br>Timonium, Md. 21093   |  |   |                             |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>James F. Gladden  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Leonard J. Ruck Inc. 5305 Harford Rd. 21214  |  |   |                             |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Head & Neck Injury<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF):<br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |  |  |   |                             | Approximate interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   |                             | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 6 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |                             |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br>9/28/90   |  | 28b. TIME OF INJURY<br>9:21P M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                             | 28d. DESCRIBE HOW INJURY OCCURRED<br>Subject was passenger in rear bed of pick-up truck ejected.          |  |  |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Mario F. Golle, Jr., M.D.   |  | 29c. LICENSE NUMBER<br>OCME  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/30/90  |                             |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Mario F. Golle, Jr., M.D. 111 Penn St. Baltimore, Md. 21201   |  |  |  |  |  |   |                             | 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26869

|  |  |  |  |   |                                |  |   |   |  |  |  |                                   |  |
|--|--|--|--|---|--------------------------------|--|---|---|--|--|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARY A MARTIN</b> (MARY ADELL MARTIN)   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPTEMBER 23, 1990</b>   |                                | 3. TIME OF DEATH<br><b>1:44 P M</b>                      |   |   |  |  |  |                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>225-12-4273</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.  |                                | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>8-11-13</b> |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>VA.</b>  |  |  |  |                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |                                |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>                            |   |  |  |  |                                   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE, CITY</b>   |                                |  |   | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |  |  |                                   |  |
| 10e. STREET AND NUMBER<br><b>2821 W. MULBERRY STREET</b>   |  |  |  | 10f. ZIP CODE<br><b>21223</b>   |                                | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>              |   |   |  |  |  |                                   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |   |  |  |  |                                   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5th</b><br>College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>DOMESTIC</b>   |  |   | 16b. KIND OF BUSINESS/INDUSTRY |  |   |   |  |  |  |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>CAROL DAVIS</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>VERGIE REDMOND</b>  |                                |  |   |   |  |  |  |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DOROTHY L. WILLIAMS</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1721 E. LAFAYETTE AVE. - BALTIMORE, MD 21213</b>  |                                |  |   |   |  |  |  |                                   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>KING MEMORIAL PARK</b>  |  | 20c. LOCATION — City or Town, State<br><b>RANDALLSTOWN, MD.</b>   |                                |  |   |   |  |  |  |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Daneshu Coad</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>  |                                |  |   |   |  |  |  |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Adult Respiratory Distress Syndrome</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |                                |  |   | Approximate Interval Between Onset and Death<br><b>Days</b>   |  |  |  |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |                                |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input checked="" type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |                                | 28a. DATE OF INJURY (Month, Day, Year)                   |   | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>MD Senior Medical Resident</i>   |  | 29c. LICENSE NUMBER   |                                | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/23/90</b>    |   |   |  |  |  |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Johns Hopkins Hospital 600 N WOLFE ST. BALTO.MD. 21205</b>   |  |  |  |   |                                |  |   |   |  |  |  |                                   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>SEP 27 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |                                |  |   |   |  |  |  |                                   |  |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be brought to the funeral home to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 90 26870  |  |   |  |
|--|--|---|--|--|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH   |  |   |  | REG. NO.   |  |  |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Rosa Mathisen  |  |   |  | 2. DATE OF DEATH<br>MONTH 9 DAY 29 YEAR 90   |  |  |  | 3. TIME OF DEATH<br>M   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>214 18 2756   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>81 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>11-6-1908 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>North Arundel Hospital   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Glen Burnie   |  |  |  | 9c. COUNTY OF DEATH<br>Anne Arundel   |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Anne Arundel   |  | 10c. CITY, TOWN OR LOCATION<br>Glen Burnie   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br>7865 Crilley Road Apt. 485B  |  |   |  | 10f. ZIP CODE<br>21060   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)   |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife   |  | 15b. KIND OF BUSINESS/INDUSTRY<br>Home Maker   |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Lou Cohen   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Annie Hare  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>George Flynn   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>249 Carvel Road Riviera Beach, Maryland 21122   |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Voshell Memorial Gardens  |  | 20c. LOCATION — City or Town, State<br>Baltimore, Maryland   |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>► Jerome Znamkowski   |  | 22. NAME AND ADDRESS OF FACILITY<br>George J. Gonce Funeral Home P.A.<br>4001 Ritchie Hwy. Baltimore, Md. 21225   |  |  |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. Exacerbation of Chronic Obstructive Pulmonary Disease<br>c.<br>d.<br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Atherosclerotic Cardiovascular Disease |  |   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)           |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>W. H. M. Attending Doctor   |  |  |  | 29c. LICENSE NUMBER<br>D21684   |  | 29d. DATE SIGNED (Month, Day, Year)<br>► 10.1.90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>C.V. CYRIAC, M.D. 1600 CRAIN HWY SUITE 308. GLENBURNIE MD 21061   |  |   |  |  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 2 - 1990  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |  |  |  |   |  |   |  |



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

90 26871

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>G. BOWERS MANSDORFER  |  |   |  | 2. DATE OF DEATH<br>MONTH 9 - DAY 28 - YEAR 90  |  | 3. TIME OF DEATH<br>7:00A.M.  |   |
| 4. SOCIAL SECURITY NUMBER<br>220-44-0538  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>86 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>10-3-1903                                   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>213 GATESWOOD ROAD  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>TIMONIUM   |  | 9c. COUNTY OF DEATH<br>BALTIMORE  |   |
| 10a. STATE<br>MD.   |  |   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE, CITY  |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br>2937 NORTH CHARLES STREET   |  |   |   |
| 10f. ZIP CODE<br>21218  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE                      |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 8  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>PHYSICIAN  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>MEDICINE  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>GEORGE W. MANSDORFER   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>DELILAH CRAMER   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>M. CATHERINE PETRICH  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>213 GATESWOOD ROAD, TIMONIUM, MD. 21093  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>WOODLAWN CEMETERY   |  | 20c. LOCATION — City or Town, State<br>WOODLAWN, MD. 21207  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Edwin M. Perkins   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>4905 YORK ROAD 21212<br>H.W. JENKINS AND SONS, BALTO, MD.   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Congestive Heart Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Arteriosclerotic Cardiovascular<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Coronary Artery Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |   | Approximate Interval Between Onset and Death<br>2 years   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)          |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>John R. Davis, MD  |
| 29c. LICENSE NUMBER<br>D-02300  |  |   |  |   |  |   | 29d. DATE SIGNED (Month, Day, Year)<br>9/28/90  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>JOHN R. DAVIS 101 W. READ STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>OCT 2 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

DHMH.18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within \_\_\_\_\_ hours after death. Page 6 may be retained by the hospital or attending physician for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. cremation, or removal.

14732. 110

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26873

|  |  |   |  |   |   |   |   |   |  |
|--|--|---|--|---|---|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mark Plungian</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>27</b> YEAR <b>90</b>   |   | 3. TIME OF DEATH<br><b>1650</b> M                     |   |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>280-03-7295</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS   |   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>3/31/04</b> |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Lithuania</b>                                    |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Hebrew Home</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville, MD</b>   |   |   | 9c. COUNTY OF DEATH<br><b>Montgomery</b>                                |   |  |
| 10a. STATE<br><b>Virginia</b>  |  | 10b. COUNTY<br><b>Arlington</b>   |  | 10c. CITY, TOWN OR LOCATION   |   |   |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>1515 S. Jefferson Davis Hwy. #301</b>   |  |   |  | 10f. ZIP CODE<br><b>22202</b>   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>           |   |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |   |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b> |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>8</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Research Chemist</b>   |   |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Hercules Powder Corporation</b>    |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Israel Plungian</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Chana Taube Alexander</b>   |   |   |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Claire Gilbert</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10324 Dickens Ave., Bethesda, Md. 20814</b>   |   |   |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Elesavetgrad Cemetery</b>  |  |   | 20c. LOCATION — City or Town, State<br><b>Wash., D.C.</b> |   |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Caputo</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ives-Pearson Funeral Homes<br/>Falls Church, Va. 22046</b>   |   |   |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Metastatic Bladder Cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><br>25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><br>26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)<br><br>27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined<br><br>28a. DATE OF INJURY (Month, Day, Year)<br><br>28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO<br><br>28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO<br><br>28d. DESCRIBE HOW INJURY OCCURRED<br><br>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><br>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><br>29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><br>29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Barbara Carroll, MD</b><br><br>29c. LICENSE NUMBER<br><b>D38392</b><br><br>29d. DATE SIGNED (Month, Day, Year)<br><b>9/27/90</b><br><br>30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BARBARA CARROLL, MD 6105 MONTROSE RD, ROCKVILLE</b><br><br>31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b><br><br>REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b> |  |   |  |   |   |   |   |   |  |





STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

90 26874

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Robert F. Phillips</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09/29/90</b>   |  | 3. TIME OF DEATH<br><b>M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>188 14 3151</b>  |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>70</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2 20 PENNA.</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>FRANCIS SCOTT KEY</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>DUNDALK</b>   |  | 9c. COUNTY OF DEATH<br><b>BALTO.</b>   |  |
| 10a. STATE<br><b>MD.</b>   |  |  |  | 10b. COUNTY<br><b>BALTO.</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>DUNDALK</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>7300 SCHOOL AVE</b>   |  |  |  | 10f. ZIP CODE<br><b>21222</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br><b>2</b> <input checked="" type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12+H</b><br>College (1-4 or 5+) <b>-</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>FOREMAN</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>CHESAPEAKE MACHINE CO.</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>LOUIS PHILLIPS</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SUSAN GESSNER</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DELORIS PHILLIPS</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7300 SCHOOL AVE</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CHRIST LUTHERAN CEM.</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTO. COUNTY</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Colt Connolly</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Connolly Funeral Home of Dundalk</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. SMALL CELL CANCER METASTATIC TO LIVER</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d.</b> |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>7 MO</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO  |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input checked="" type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation<br><b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined<br><b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO   |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature]</b>  |  | 29c. LICENSE NUMBER<br><b>038683</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>OCT 01, 1990</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

90 26875

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Robert William Pinault</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept. 29, 1990</b>   |  | 3. TIME OF DEATH<br><b>12:30 PM</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>037-09-7192</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>11/02/03</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Massachusetts</b>  |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br><b>301-C Sunshine Place 21228</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Catonsville</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Catonsville</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>301-C Sunshine Place</b>  |  |  |  | 10f. ZIP CODE<br><b>21228</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>2</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Textile Chemist</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Cotton Finishing</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Zephrim Ralph Pinault</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Alma Louise Rushworth</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Olive G. Pinault</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>301-C Sunshine Pl. Catonsville, MD 21228</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><br><b>George E. MacNabb</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Cremation Society of Md., Inc.<br/>299 Frederick Rd. Balto., MD 21228</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  | <input checked="" type="checkbox"/> <b>Metastatic hepatoma</b><br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  | b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
|  |  | d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>Bruce Conger, M.D.</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D37013</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>09/30/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Bruce Conger, M.D. 11055 Little Patuxent Pkwy. Columbia, MD 21044</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



REG. NO.

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 6 should be retained by the funeral director, page 5 should be detached and sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26877

|  |  |   |  |   |  |   |   |   |  |  |  |
|--|--|---|--|---|--|---|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CECILIA A. PULIGNANI</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 30, 1990</b>   |  | 3. TIME OF DEATH<br><b>5:08 P M</b>   |   |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-01-7450</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Sept. 11, 1917</b>                             |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Franklin Square Hospital</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rossville</b>   |  |   | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |   |  |  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>6133 Marglenn Ave.</b>  |  |   |  | 10f. ZIP CODE<br><b>21206</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                      |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b></b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |   |   |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Ahrend C. Hartman</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marguerite Medicus</b>  |  |   |   |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Alexander J. Pulignani</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6133 Marglenn Ave., Baltimore, MD 21206</b>   |  |   |   |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Green Mount Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>   |  |   |   |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>ROBERT C. ALTENBURG FUNERAL HOME, INC.</b><br><b>6009 Harford Rd., Baltimore, MD 21214</b>   |  |   |   |   |  |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrhythmia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>CITF</b><br>Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>VALVULAR HEART DISEASE</b><br><b>RHEUMATIC FEVER</b> |  |   |  |   |  |   |   | Approximate Interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>   |  |   |  |   |  |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |   |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |   |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |   |  |   |  | 29c. LICENSE NUMBER   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>10-1-90</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type, Print)<br><b>JOSE A. HERNANDEZ M.D. / OLIVER MEDICAL CENTER TOWSON, MD. 21204</b>   |  |   |  |   |  |   |   |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 2 - 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |   |   |  |  |  |

57142 BP



90 26878

|  |  |  |  |  |  |   |  |   |  |  |  |
|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Otto Rehak</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>27</b> YEAR <b>90</b>  |  |   |  | 3. TIME OF DEATH<br><b>4:20 A M</b>   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-01-1447</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>April 24, 1917</b>                             |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Keswick Home</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>   |  |   |  | 9c. COUNTY OF DEATH   |  |  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><b>5010 Plainfield Ave.</b>  |  |  |  | 10f. ZIP CODE<br><b>21206</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                  |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Engineer</b>             |  | 16b. KING OF BUSINESS/INDUSTRY<br><b>Quality Control</b>   |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph Rehak</b>   |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marie Swoboda</b>  |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Geraldine Rehak</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as #10</b>  |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Meadowridge Cemetery 10/1/90</b>                                |  |  |  | 20c. LOCATION — City or Town, State<br><b>Elkridge, Md.</b>                                 |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd., Towson, Md. 21204</b>   |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {<br>b. <b>Hypertensive arteriosclerotic cardiovascular disease</b><br>c. <b>Multiple cerebral/cerebellar infarcts</b><br>d. _____<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____<br>_____<br>_____ |  |  |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>M. Isabelle MacGregor MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D13657</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-27-90</b>                                       |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>M. ISABELLE MACGREGOR, KESWICK, 700 W. 40th STREET, BALTIMORE, MD 21211</b>  |  |  |  |  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 2 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |  |  |  |



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
**CERTIFICATE OF DEATH**

1 - FOR  
 STATE  
 REGISTRAR

REG. NO. **90 26879**

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MINERVA AMANDA ROHRER</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>28</b> , YEAR <b>1990</b><br>DAY <b>28</b> MONTH <b>SEPT.</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>2:10 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>298-26-5385</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>76</b> YRS.  |  | 7. DATE OF BIRTH<br>MONTH <b>Aug.</b> , DAY <b>11</b> , YEAR <b>1914</b>                        |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Kentucky</b>   |  |   |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Harbor Hospital Center</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore, City</b>   |  |
| 10a. STATE<br><b>Maryland</b>   |  |   |  | 10b. COUNTY<br><b>Anne Arundel</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Glen Burnie</b>   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>2707 Wren Way</b>  |  |   |  | 10f. ZIP CODE<br><b>21060</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th.</b><br>College (1-4 or 5+)<br><b>NONE</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Registered Nurse</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Hospital</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph Davis</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ruby Welch</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Gwendolyn Manross</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2707 Wren Way, Glen Burnie, Maryland 21060</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mentor Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Mentor, Ohio</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>R. Henry Hopkins</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Singleton Funeral Home</b><br><b>1 Second Ave. S. W. Glen Burnie, Maryland 21061</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Massive (2) CVA &amp; cerebral edema</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>↑ Intracranial Pressure → Herniation</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Hyperextension</b><br><b>SLE &amp; kidney involvement</b><br><b>Hypochloremia</b><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hyperextension</b><br><b>SLE &amp; kidney involvement</b><br><b>Hypochloremia</b> |  |   |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> M.D.  |  |   |  | 29c. LICENSE NUMBER<br><b>AS 2941614</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/28/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 6 may be retained by the hospital for medical purposes. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26880

|   |  |  |  |  |                                     |  |  |   |  |
|---|--|--|--|--|-------------------------------------|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>William T. Rhoades</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>9</i> DAY <i>26</i> YEAR <i>90</i>  |                                     | 3. TIME OF DEATH<br><i>11:00 P.M.</i>  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>218-03-3291</i>   |  | 5. SEX<br><i>1</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>73</i> YRS.   |                                     | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>OCT. 3. 1916</i>                                      |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>MARYLAND</i> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>MASON-LORD NURSING CENTER</i>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>BALTIMORE CITY</i>   |                                     |  | 9c. COUNTY OF DEATH<br><i>BALTIMORE CITY</i>   |   |  |
| 10a. STATE<br><i>MARYLAND</i>   |  | 10b. COUNTY<br><i>BALTIMORE CITY</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>BALTIMORE CITY</i>   |                                     |  | 10d. INSIDE CITY LIMITS?<br><i>1</i> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br><i>6805 E. BALTIMORE STREET</i>   |  |  |  | 10f. ZIP CODE  |                                     | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  |   |  |
| 11. MARITAL STATUS<br><i>1</i> <input type="checkbox"/> Never Married <i>2</i> <input type="checkbox"/> Married<br><i>3</i> <input type="checkbox"/> Widowed <i>4</i> <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>XXX</i> YES <i>2</i> <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>1944-46</i> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO Specify:  |                                     |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>WHITE</i>                               |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>UNKNOWN</i><br>College (1-4 or 5+) <i>NO</i>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>PIPEFITTER</i>   |                                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>INDUSTRIAL</i>  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>WILLIAM T. RHOADES</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>MARGARET ( VICKERS )</i>   |                                     |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>MR. THOMAS RHOADES</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>7738 OVERLAND ROAD. PASADENA. MARYLAND</i>   |                                     |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><i>1</i> <input checked="" type="checkbox"/> Burial <i>2</i> <input type="checkbox"/> Cremation <i>3</i> <input type="checkbox"/> Removal from State<br><i>4</i> <input type="checkbox"/> Donation <i>5</i> <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>MARYLAND VETERAN'S CEMETERY. CROWNSVILLE. MD</i>                  |  |  | 20c. LOCATION — City or Town, State |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Shane Savage</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>MC CULLY FUNERAL HOME OF PASADENA<br/>3204 MOUNTAIN ROAD. PASADENA. MD 21122</i>  |                                     |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. respiratory arrest</i> RESPIRATORY ARREST<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>b. end stage COPD</i><br><i>c. pelvic abscess</i> PELVIC ABCESS<br><i>d. sepsis</i> SEPSIS |  |  |  |  |                                     |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>None</i>   |  |  |  |  |                                     |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><i>1</i> <input type="checkbox"/> YES <i>2</i> <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <i>1</i> <input type="checkbox"/> Inpatient <i>2</i> <input type="checkbox"/> ER/Outpatient <i>3</i> <input type="checkbox"/> DOA<br>OTHER: <i>4</i> <input checked="" type="checkbox"/> Nursing Home <i>5</i> <input type="checkbox"/> Residence <i>6</i> <input type="checkbox"/> Other (Specify) |                                     |  |  |   |  |
| 27. MANNER OF DEATH<br><i>1</i> <input checked="" type="checkbox"/> Natural <i>5</i> <input type="checkbox"/> Pending Investigation<br><i>2</i> <input type="checkbox"/> Accident <i>3</i> <input type="checkbox"/> Suicide <i>4</i> <input type="checkbox"/> Homicide <i>6</i> <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><i>M</i>  |                                     | 28c. INJURY AT WORK?<br><i>1</i> <input type="checkbox"/> YES <i>2</i> <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                           |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |                                     |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><i>1</i> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><i>2</i> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |                                     |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John C. Ogden MD</i>  |  |  |  | 29c. LICENSE NUMBER  |                                     | 29d. DATE SIGNED (Month, Day, Year)<br><i>9/27/90</i>  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |  |                                     |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>OCT 02 1990</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |                                     |  |  |   |  |



**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

90 26881

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Leroy Thomas Russell</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH <i>Sept.</i> DAY <i>29</i> YEAR <i>1990</i>   |  | 3. TIME OF DEATH<br><i>4:00 AM</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>217-12-5349</i>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 5. AGE (In yrs. last birthday)<br><i>67</i> YRS. | IF UNDER 1 YEAR<br>MONTHS _____ DAYS _____  |  | IF UNDER 24 HRS.<br>HOURS _____ MIN. _____  |  |
| 6. DATE OF BIRTH<br>(Month, Day, Year)<br><i>11-13-22</i>   |  |  |  | 7. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>16 Lake Haven</i>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Berlin</i>  |  | 9c. COUNTY OF DEATH<br><i>Worcester</i>   |  |
| 10a. STATE<br><i>Md.</i>  |  | 10b. COUNTY<br><i>Worcester</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Berlin</i>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><i>16 Lake Haven</i>  |  |  |  | 10f. ZIP CODE<br><i>21811</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES <i>WW 2</i>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: _____ |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) _____ College (1-4 or 5+) <i>4 years</i>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Maintenance Engineer</i>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>State of Maryland</i>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Charles A. Russell, Sr.</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Marie A. Dorsey</i>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Mr. Thomas Russell</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>48 Far Corners Loop Sparks, MD 21152</i>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Carroll Cremation, Inc.</i>   |  | 20c. LOCATION — City or Town, State<br><i>Hampstead, MD</i>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>John K. [Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Loring Byers Funeral Directors, Inc.<br/>8728 Liberty Rd. Randallstown, MD 21133</i>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Atherosclerotic Cardiovascular Disease</i><br>DUE TO (OR AS A CONSEQUENCE OF): _____<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. _____ DUE TO (OR AS A CONSEQUENCE OF): _____<br>c. _____ DUE TO (OR AS A CONSEQUENCE OF): _____<br>d. _____ |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Chronic Obstructive Pulmonary Disease</i>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____ |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John S. Bullock Deputy ME</i>  |  | 29c. LICENSE NUMBER<br><i>103599</i>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>10-1-90</i>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>OCT 02 1990</i>   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND, 21268-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital, but the attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |  |  |   |  | 90 26882                                     |  |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1 - FOR STATE REGISTRAR  |  |  |  |   |  |  |  |   |  | REG. NO.                                     |  |
| CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>MARIEKA Michelle RANDOLPH</i><br><i>(Smith, Baby Girl of Edith)</i>   |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH <i>9</i> DAY <i>24</i> YEAR <i>90</i>  |  | 3. TIME OF DEATH<br><i>7 58 P M</i>   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>N/A</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>01</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>8/24/90</i>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i>                                     |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>University of Maryland NICU</i>   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore</i>  |  | 9c. COUNTY OF DEATH<br><i>USA</i>   |  |  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |   |  |  |  |
| 10a. STATE<br><i>MD</i>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><i>Baltimore</i>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |  |  |
| 10e. STREET AND NUMBER<br><i>2204 Cecil Ave</i>  |  |  |  | 10f. ZIP CODE<br><i>21218</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  |   |  |  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>Black</i>                         |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><i>Child</i>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>child</i>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Phillip Randolph</i>   |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Edith M</i>  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Phillip RANDOLF</i>   |  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2204 Cecil Ave - Baltimore, MD 21218</i> |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Baltimore cemetery</i>   |  |  |  | 20c. LOCATION — City or Town, State<br><i>Baltimore, MD</i>                                     |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Gladys Warren</i>  |  |  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>WM C. MARCH F.H. 1101 E. North Ave</i>  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death |  |
| a. <i>Respiratory Insufficiency</i>  |  |  |  |   |  |  |  |   |  | 4 days                                       |  |
| b. <i>Pneumonia</i>  |  |  |  |   |  |  |  |   |  | 4 days                                       |  |
| c. <i>Hyperkalemia</i>   |  |  |  |   |  |  |  |   |  | 1 day  |  |
| d. <i>Cardiac arrhythmia</i>   |  |  |  |   |  |  |  |   |  | 1 day  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  | 28d. DESCRIBE HOW INJURY OCCURED             |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                    |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                         |  |  |  |   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Sunil Gupta MD</i>   |  |  |  |   |  | 29c. LICENSE NUMBER<br><i>D33182</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9-24-90</i>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>SUNIL GUPTA MD, UNIV. OF MARYLAND HOSPITAL, BALTIMORE, MD</i>  |  |  |  |   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>OCT 02 1990</i>  |  |  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randell</i>  |  |   |  |  |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26883

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>William SYDNER</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>26</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>1:00 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>231443463</b>  |  | 5. SEX<br><b>1</b> M <b>2</b> F   |  | 6. AGE (In yrs. last birthday)<br><b>55</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11-19-34</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Virginia</b>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>SETON HILL MANOR</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  |
| 9c. COUNTY OF DEATH  |  |   |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><b>XX</b> YES <b>2</b> NO   |  | 10e. STREET AND NUMBER<br><b>101 Franklin Street</b>  |  |
| 10f. ZIP CODE<br><b>21217</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br><b>XX</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>XX</b> NO<br>IF YES, GIVE WAR OR DATES                              |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> YES <b>XX</b> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Unemployed</b> |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>N/A</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Arthur Sydnor</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Edith Johnson</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ruth Veney</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2826 Boarman Avenue Balto., Md. 21215</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Zion Cemetery</b>                              |  | 20c. LOCATION — City or Town, State<br><b>Landsdowne, Maryland</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Derrick C. Jones</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Derrick C. Jones F.H.<br/>4611 Park Heights Avenue Balto., Md. (15)</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>AIDS (HIV Infection) + Pos. for 2 opportunistic infections</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <b>Due to (OR AS A CONSEQUENCE OF):</b><br/> <b>Due to (OR AS A CONSEQUENCE OF):</b><br/> <b>Due to (OR AS A CONSEQUENCE OF):</b><br/> <b>Due to (OR AS A CONSEQUENCE OF):</b> </div> <div style="width: 30%; border-left: 1px solid black; padding-left: 10px;"> <b>Approximate Interval Between Onset and Death</b><br/> <b>3 yrs.</b> </div> </div> |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CNS toxoplasmosis</b><br><b>Meningitis</b><br><b>Dementia</b>   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> YES <b>2</b> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> YES <b>2</b> NO   |  |   |  |   |  | 26. PLACE OF DEATH (Check only one)<br><b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |
| 27. MANNER OF DEATH<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> YES <b>2</b> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  | 29a. CERTIFIER (Check only one)<br><b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>James Ponzalan</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>01224</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/26/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. PUNZALAN 5214 Harford rd. Balto. MD. 21214</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 90 26884

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Catherine Stevens  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 27, 1990   |  | 3. TIME OF DEATH<br>P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>157 12 0216   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (in yrs. last birthday)<br>78 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Nov. 8, 1911   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Pennsylvania   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>17609 Prince David Drive   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Olney   |  |
| 9c. COUNTY OF DEATH<br>Montgomery  |  |  |  | 10a. STATE<br>NJ   |  | 10b. COUNTY<br>Hudson  |  |
| 10c. CITY, TOWN OR LOCATION<br>Jersey City   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>284 Bowers St.   |  |
| 10f. ZIP CODE<br>07307   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9 College (1-4 or 5+)  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Home   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Martin Moran  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Marie Finan   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Catherine Nichols  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>220 Bowers St., Jersey City, NJ 07307   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Holy Cross Cemetery  |  |  |  |
| 20c. LOCATION — City or Town, State<br>No. Arlington, NJ   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br>Lives-Pearson Funeral Homes<br>Arlington, Va. 22201  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Liver failure</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>metastasis to liver</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>Gastric adenocarcinoma</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>28b. TIME OF INJURY<br>M<br>28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>28d. DESCRIBE HOW INJURY OCCURRED<br>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |  |  |
| 29c. LICENSE NUMBER<br>013832  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>27 Sept 90  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

Y0570 09


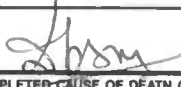

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 90 26885  |  |                                |  |  |  |
|--|--|---|--|---|--|---|--|---|--|--------------------------------|--|--|--|
| CERTIFICATE OF DEATH   |  |   |  | REG. NO.  |  |   |  |   |  |                                |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>JOHN HENRY SNYDER  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>SEPT. 30 90   |  | 3. TIME OF DEATH<br>4:00 A M  |  |   |  |                                |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>213-28-3045   |  | 6. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>59 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>FEB. 12, 1931   |  | 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND  |  |                                |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>VA MEDICAL CENTER  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>FT. HOWARD   |  | 9c. COUNTY OF DEATH<br>BALTIMORE  |  |   |  |                                |  |  |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |  |   |  |                                |  |  |  |
| 10a. STATE<br>MARYLAND   |  | 10b. COUNTY<br>ANNE ARUNDEL   |  | 10c. CITY, TOWN OR LOCATION<br>HANOVER  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |                                |  |  |  |
| 10e. STREET AND NUMBER<br>P.O. BOX 382   |  |   |  | 10f. ZIP CODE<br>21076  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |                                |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>7/50 to 7/53 Korean |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                                 |  |   |  |                                |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8   |  | 15b. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>PAINTER  |  | 15c. KIND OF BUSINESS/INDUSTRY<br>HOUSE PAINTER   |  |   |  |   |  |                                |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>WILMER WOLFE SNYDER   |  |   |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br>HILDA NAOMI HESS   |  |   |  |   |  |                                |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Rose P. Snyder   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>912 Reece Road, Severn, MD 21144   |  |   |  |   |  |                                |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>METRO CREMATORY INC.  |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MD  |  |   |  |   |  |                                |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>SINGLETON FUNERAL HOME<br>1 Second Ave. S.W. Glen Burnie, MD 21061  |  |   |  |   |  |                                |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary Arrest due to Carcinoma R Lung<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |                                |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO                                   |  |                                |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |                                |  |  |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  |                                |  |  |  |
| 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |                                |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |                                |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>                |  | 29c. LICENSE NUMBER<br>D 30528 |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/30/90 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DR. M. BALA DUGGIRALA, MD. VA MEDICAL CENTER, FORT HOWARD, MARYLAND 21052   |  |   |  |   |  |   |  |   |  |                                |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |  |                                |  |  |  |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26886

|   |  |  |  |   |  |  |   |  |   |  |
|---|--|--|--|---|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>JOHN HARRY SELIG, JR.   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 26 1990   |  | 3. TIME OF DEATH<br>9:13 P.M.  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>220-18-7802  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>64 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Aug. 27, 1926                                 |   | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>539 Kenora Drive  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Millersville   |  |  | 9c. COUNTY OF DEATH<br>Anne Arundel   |  |   |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Anne Arundel  |  | 10c. CITY, TOWN OR LOCATION<br>Millersville   |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br>539 Kenora Drive  |  |  |  | 10f. ZIP CODE<br>21108  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>W.W.II, Korean, Viet.  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                       |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12th   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>College (1-4 or 5+)<br>None   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>S.F.C. E7   |  | 16c. KIND OF BUSINESS/INDUSTRY<br>US ARMY  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Harry Selig, Sr.  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Minnie Drexler   |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Jeanine R. Selig   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same as 10   |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Maryland Veterans Cemetery   |  | 20c. LOCATION — City or Town, State<br>Crownsville, Maryland  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>R. Henry Higgins   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>SINGLETON FUNERAL HOME<br>1 SECOND AVE. S.W., GLEN BURNIE, MD. 21061  |  |  |   |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LUNG CANCER<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br>1 XR  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>BRAIN METASTASES  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED                    |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>[Signature] MD  |  |   |  | 29c. LICENSE NUMBER<br>D35606  |   | 29d. DATE SIGNED (Month, Day, Year)<br>9/27/90       |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Samuel Zyglar MD, 3100 Wyman Park Drive, Rm. 303, Baltimore, Maryland 21211  |  |  |  |   |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |   |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as a transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 90 26887  |  |  |  |                                   |  |
|--|--|--|--|---|--|--|--|---|--|--|--|-----------------------------------|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |   |  |  |  |                                   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>DOROTHY JANE STEWART   |  |  |  | 2. DATE OF DEATH<br>28, 1990<br>SEPT. 28 90   |  |  |  | 3. TIME OF DEATH<br>11:30 P.M.  |  |  |  |                                   |  |
| 4. SOCIAL SECURITY NUMBER<br>499-16-3081   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>82 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>August 13, 1908           |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  |                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Harbor Hospital Center   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  |  |  | 9c. COUNTY OF DEATH<br>Baltimore City   |  |  |  |                                   |  |
| 10a. STATE<br>Maryland   |  |  |  | 10b. COUNTY<br>Anne Arundel   |  | 10c. CITY, TOWN OR LOCATION<br>Glen Burnie                       |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |  |  |                                   |  |
| 10e. STREET AND NUMBER<br>7216 Ritchie Highway   |  |  |  | 10f. ZIP CODE<br>21061  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                          |  |   |  |  |  |                                   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White |  |   |  |  |  |                                   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12th.  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>College (1-4 or 5+)<br>2 Years<br>Secretary - Manager  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Key Biscayne Hotel<br>Miami, Florida  |  |  |  |   |  |  |  |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Benjamin Ireland  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Nettie Catterton   |  |  |  |   |  |  |  |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. Charles G. Taylor  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7216 Ritchie Highway, Glen Burnie, Maryland 21061  |  |  |  |   |  |  |  |                                   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Glen Haven Memorial Park   |  | 20c. LOCATION — City or Town, State<br>Glen Burnie, Maryland  |  |  |  |   |  |  |  |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>R. George Hopkins   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>SINGLETON FUNERAL HOME<br>1 Second Ave. S.W., Glen Burnie, Maryland 21061   |  |  |  |   |  |  |  |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebral vascular accident<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |  |  |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Hypertension<br>respiratory arrest   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)                           |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                     |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Eric Kranz  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/28/90                   |  |   |  |  |  |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>ERIC KRANZ H-H.C. Balt Md. 21230  |  |  |  |   |  |  |  |   |  |  |  |                                   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randella  |  |  |  |   |  |  |  |                                   |  |



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26888

|   |  |   |  |   |  |   |   |
|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Russell STRAUSSER</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>September 30, 1990</b>   |  | 3. TIME OF DEATH<br><b>3:23 p m</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>205-03-4678</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>March 8, 1912</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>PA.</b>  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Franklin Square Hospital</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rossville</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |   |
| RESIDENCE OF DECEDENT   |  |   |  |   |  |   |   |
| 10a. STATE<br><b>Md.</b>  |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Essex</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>618 Virginia Ave.</b>  |  |   |  | 10f. ZIP CODE<br><b>21221</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                         |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Martin Marietta</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Strausser</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elizabeth Strausser</b>   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dorothy Strausser</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>618 Virginia Ave. Baltimore Md. 21221</b>   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore Md.</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Connelly Funeral Home</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Connelly Funeral Home 300MAceAve. 21221</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>e. Massive Gastro-Intestinal Bleed</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                                   |
|   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |   |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |   |
|   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Kevin H. Scruggs</i>  |  |   |  | 29c. LICENSE NUMBER<br><b>D 38543</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/30/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Kevin Scruggs MD. 9000 Franklin Square Dr. Balto, Md. 21237</b>   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Hendall</i>  |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-0146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use on the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Jerome C. St. Jean   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9 29 90  |  | 3. TIME OF DEATH<br>11:40 A.M.  |  |
| 4. SOCIAL SECURITY NUMBER<br>217-20-3193   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>63 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>3-13-27  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>6601 Walther Ave.   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City  |  | 9c. COUNTY OF DEATH<br>Baltimore City   |  |
| RESIDENCE OF DECEDENT  |  |   |  |  |  |   |  |
| 10a. STATE<br>MD   |  | 10b. COUNTY<br>Baltimore City   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>6601 Walter Ave Apt. 2A  |  | 10f. ZIP CODE<br>21206  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW II |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th<br>College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Westing House                               |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Westing House  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Albert C. St. Jean  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mabel V. Clocker  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Donald St. Jean  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1502 Chesaco Ave. Baltimore, MD 21237   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery   |  | 20c. LOCATION — City or Town, State<br>Anne Arundel, MD  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Quach/Rosedale Funeral Home Inc.<br>1211 Chesaco Ave. Rosedale, MD 21237   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |   |  |  |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |   |  | 29c. LICENSE NUMBER<br>OCME  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/30/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ann M. Dixon, M.D. 111 Penn St. Baltimore, Md. 21201  |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit form.

IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

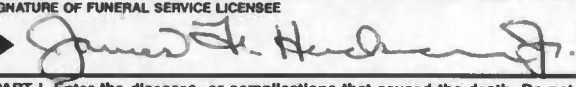
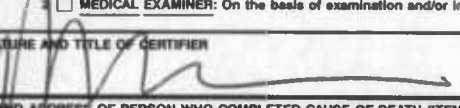
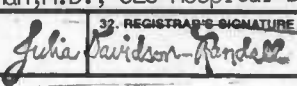
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26890

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FRANCES M STROHMER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>29</b> YEAR <b>1990</b>  |  | 3. TIME OF DEATH<br><b>2:35 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-70-4270</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>3/9/1908</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>North Arundel Hospital, 301 Hospital Drive</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Glen Burnie</b>   |  |
| 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>  |  |  |  |   |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>A.A.Co.Md.</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Glen Burnie, Md.</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>1757 Marley Ave.</b>   |  |  |  | 10f. ZIP CODE<br><b>21061</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th. Grade</b><br>College (1-4 or 5+) <b>-----</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Own Home</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph ---- Dougherty</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Eva --- Miloiewski</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. Charles Dougherty</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1604 Annapolis Dr. Glen Burnie, Md. 21061</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>New Cathedral Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Balto. Md.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Pasadena, Md. 21122<br/>McCully funeral Home, 3204 Mt. Rd.</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>1 day</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>MD 26664</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/20/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Paul J. Young-Hyman, M.D., 325 Hospital Drive, Glen Burnie, Maryland 21061</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26891

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Michael Rudolph Sedges Sr.   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09 29 1990  |  | 3. TIME OF DEATH<br>10:20 P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>135-56-2770   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>34 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Dec. 20, 1955  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE  |  | 9c. COUNTY OF DEATH<br>BALTIMORE CITY  |  |
| 10a. STATE<br>N.J.   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>Union  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br>1701 A Walker Avenue   |  |  |  | 10f. ZIP CODE<br>07083  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>2/21/78 - 3/12/80   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>2   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Auto Appraiser  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Risk Management Co.   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Rudolph Sedges  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Rosemarie Malagregga   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Anita Sedges   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1701 A Walker Avenue Union, N.J. 07083   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Gate of Heaven October 3, 1990   |  | 20c. LOCATION — City or Town, State<br>East Hanover, N.J.   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>James F. Gladden <i>James F. Gladden</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Leonard J. Ruck Inc. 5305 Harford Rd. 21214   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  | Approximate Interval Between Onset and Death   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |   |  | 9 days   |  |
| a. SEPSIS<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  | 11 days  |  |
| b. BONE MARROW TRANSPLANT<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  | 9 mos.   |  |
| c. HODGKIN'S DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| d.   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>ACUTE RENAL FAILURE<br>LIVER FAILURE   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>David P. McCarron MD - INTERN/DEPT. INT MED   |  | 29c. LICENSE NUMBER<br>J2070  |  | 29d. DATE SIGNED (Month, Day, Year)<br>09/29/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DAVID P. MCCARRON MD, 1830 E. MONUMENT ST, DEPT. INT MEDICINE, BALTO. MD 21205  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randell</i>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |   | CERTIFICATE OF DEATH  |  | REG. NO.  |  | 90 26892   |  |   |  |
|--|--|---|---|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Mary Stillson  |  |   |   | 2. DATE OF DEATH<br>MONTH 9 DAY 28 YEAR 90  |  | 3. TIME OF DEATH<br>M   |  |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>218-28-9272   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br>72 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>10-26-1917   | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland |   |  |  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>4730 Hawksbury Road  |  |   |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Pikesville   |  | 9c. COUNTY OF DEATH<br>Baltimore  |  |  |  |   |  |
| 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Baltimore  |   | 10c. CITY, TOWN OR LOCATION<br>Pikesville   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |  |   |  |
| 10e. STREET AND NUMBER<br>4730 Hawksburg Road  |  | 10f. ZIP CODE<br>21208  |   | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                                 |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (9-12)<br>College (1-4 or 5+)<br>2 Years   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Legal Secretary   |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Law Firm  |  |   |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Edward Schulte  |  |   |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Ida Bohanan   |  |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Sally Schlossenberg   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4730 Hawksbury Road Pikesville, MD 21208   |   |   |  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Crestlawn Memorial Gardens  |   | 20c. LOCATION — City or Town, State<br>Marriottsville, MD   |  |   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Stephen M. Jenkins</i>   |  | 22. NAME AND ADDRESS OF FACILITY<br>Loring Byers Funeral Directors, Inc.<br>8728 Liberty Road Randallstown, MD 21133  |   |   |  |   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>retained Ca of lung</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |   |   |  |   |  | Approximate Interval Between Onset and Death   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  |   |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |   |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                        |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |   |   |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John H. Blanton</i>  |  |   |   | 29c. LICENSE NUMBER<br>D-204820   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/28/90  |  |  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>STEPHEN A. GILSON - 1777 RANDALLSTOWN RD - PIKESVILLE, MD.  |  |   |   |   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990   |  |   |   | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |  |  |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26893

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Virginia Saunders</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 27 90</b>   |  | 3. TIME OF DEATH<br><b>9:45A</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-26-1156</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>8-28-08</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>S.C.</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Joseph Richey Hospice</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balto. MD</b>  |  |
| 9c. COUNTY OF DEATH<br><b>—</b>  |  |  |  | 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>—</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Balto.</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>828 N. Eutan Street</b>   |  |
| 10f. ZIP CODE<br><b>21202</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (9-12) <b>NA</b> College (1-4 or 5+) <b>—</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>DOMESTIC</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>GRANT LEFTENANT</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>VICTORIA LEFTENANT</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Phyllis Jefferson</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>630 Hillview Ave. / Baltimore, MD 21225</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>MT. ZION CEMETERY</b>   |  | 20c. LOCATION — City or Town, State<br><b>LANSdowne, MD</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>—</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Wm. C. March Funeral Home<br/>1101 E. North Avenue 21202</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>OVERLAP CANCER WITH METS.</b>   |  |  |  |  |  |  |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |  |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>Hospice</b> |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>—</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>D-14221</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-29-90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>223 B. Blvd Baltimore T.A. Lyons</b>   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>  |  |  |  | REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |  |  |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

071 90 312 26894

|  |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>HERBERT SPENCE   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>SEPTEMBER 27, 1990  |  |  |  | 3. TIME OF DEATH<br>7P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>243 18 5571   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>68 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>10/3/21                                       |  | 8. BIRTHPLACE (State or Foreign Country)<br>NORTH CAROLINA  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>VA MEDICAL CENTER  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>FORT HOWARD  |  |  |  | 9c. COUNTY OF DEATH<br>BALTIMORE  |  |
| 10a. STATE<br>MARYLAND   |  |   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>1705 29TH STREET   |  |   |  | 10f. ZIP CODE<br>21218  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>ARMY   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>BLACK                  |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>7th  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>TRUCK DRIVER  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>ENOCH SPENCE  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ROSIE LOWERY   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>ROXIE BROCKTON   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1705 E. 29th ST.-BALTIMORE, MD. 21218  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>GARRISON FOREST VET. CEM.   |  | 20c. LOCATION — City or Town, State<br>OWINGS MILLS, MD.  |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>H. Gladys Warner  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>WM.C. MARCH F.H. 1101 E. NORTH AVE.   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. CARCINOMA OF LUNG WITH METASTASIS TO LIVER AND COLON<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>COPD<br>ANEMIA   |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|  |  |   |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>J. Davidson-Randall   |  |   |  | 29c. LICENSE NUMBER<br>D 30528  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br>SEPTEMBER 28, 1990   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |  |   |  |



90 26895

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ruth M. Sporer</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>28</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>4 45 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212 22 3108</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>6-7-1909</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Deaton Hospital + Medical Center</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH<br><b>=====</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>=====</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>3829 St. Margaret Street</b>  |  |  |  | 10f. ZIP CODE<br><b>21225</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Indian</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th Grade</b><br>College (1-4 or 5+) <b>=====</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Binder</b>                  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Binding Ind.</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Walter W. Moore</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lyda</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ronald Rinehart</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4109 Ritchie Hwy. Baltimore, Maryland 21225</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>                                       |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Jerome Znamowski</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>George J. Gonce Funeral Home P.A.<br/>4001 Ritchie Hwy. Baltimore, Md. 21225</b>   |  |  |  |
| 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cancer of Ovary</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>years</b>   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>UTI</b>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Dr. Gladus</b>   |  | 29c. LICENSE NUMBER<br><b>002384</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/28/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 2 - 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 must be attached to the hospital or attending physician.



TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 must be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the medical or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached to the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | REG. NO.             |  |
|--|--|--|--|----------------------|--|
| 1 - FOR STATE REGISTRAR  |  |  |  | CERTIFICATE OF DEATH |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>CHARLES THOMS</b>   |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 30 90</b>   |                      | 3. TIME OF DEATH<br><b>20:53 PM</b>  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-09-5342</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>82</b> YRS.   |                      | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>12-22-07</b>  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>CHURCH HOSPITAL CORPORATION</b>   |                      | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>   |
| 9c. COUNTY OF DEATH  |  |  | 10a. STATE<br><b>MD.</b>   |                      | 10b. COUNTY<br><b>BALTIMORE CITY</b>   |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE CITY</b>   |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |                      | 10e. STREET AND NUMBER<br><b>125 S LINWOOD AVE.</b>  |
| 10f. ZIP CODE<br><b>21224</b>  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                      | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |                      | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>white</b>   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unknown</b><br>College (1-4 or 5+) <b>unknown</b>   |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>assembly line work</b>   |                      | 16b. KIND OF BUSINESS/INDUSTRY<br><b>American Can</b>  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Gustav R. Thoms</b>  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Martha Weise</b>   |                      |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>LaRue Parke</b>   |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3136 Harford Road/Baltimore, MD 21218</b>  |                      |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Moreland Memorial</b>   |                      | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD</b>  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Moran-Ashton Funeral Home, Inc.<br/>3000 E. Baltimore St/Balto. MD 21224</b>  |                      |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>CONGESTIVE HEART FAILURE</b><br><b>a. Congestive Heart Failure</b><br><b>DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>b. pleural effusion</b><br><b>DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. PLEURAL EFFUSION</b><br><b>DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. </b><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> |  |  |  |                      | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |                      | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |                      |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                      |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |                      | 28b. TIME OF INJURY<br><b>M</b>  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |                      |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |                      |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |                      |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Col Alayli M.D.</b>  |  |  | 29c. LICENSE NUMBER<br><b>D39643</b>   |                      | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/30/90</b>  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Ghassan Alayli 7 Dinsmore Avenue Glen Burnie, Md 21061</b>   |  |  |  |                      |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 02 1990</b>  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |                      |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  | CERTIFICATE OF DEATH  |  | REG. NO. 90 26897  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>EUNICE G VANDENHUEK  |  |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 29 YEAR 90  |  | 3. TIME OF DEATH<br>12 40 A M  |  |
| 4. SOCIAL SECURITY NUMBER<br>273246139   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>74 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>5/17/14   |  |
| 8. FACILITY NAME (If not institution, give street and number)<br>UMMS 22 S. GREENE ST. BALTIMORE MD  |  |  |  | 9. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE MD  |  | 10. COUNTY OF DEATH<br>BALTIMORE CITY  |  |
| 10a. STATE<br>MD   |  | 10b. COUNTY<br>ANNE ARUNDEL  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br>7933 MAIN ST.  |  |  |  | 10f. ZIP CODE<br>21226  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATE  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10th grade<br>College (1-4 or 5+) none   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>HOMEMAKER   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>DOMESTIC  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOHN W. PEELER  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>LOTTIE ( UNKNOWN )   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>WILLIAM S. VANDENHUEK  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>SAME AS 10 a-f   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>METRO CREMATORY, INC., CATONSVILLE, MARYLAND   |  | 20c. LOCATION — City or Town, State<br>PASADENA, MD 21122   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Shane A. Savage   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>MC CULLY FUNERAL HOME OF PASADENA<br>3204 MOUNTAIN RD., PASADENA, MD 21122  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION c CARDIOGENIC SHOCK<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death<br>2 DAYS   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
|  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>S. Abraham MD   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/29/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>22 S. GREENE ST. BALTIMORE MD   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 2 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randell  |  |  |  |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician for use as a permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 90 26898   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |  |  |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Samuel J. Wilson, Jr.   |  |  |  | 2. DATE OF DEATH<br>MONTH 7 DAY 28 YEAR 90  |  |   |  | 3. TIME OF DEATH<br>M  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>215-22-6133  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>62 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>6 6 28 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>1154 N. Calhoun Street  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore  |  |   |  | 9c. COUNTY OF DEATH  |  |  |  |
| 10a. STATE<br>Maryland  |  |  |  | 10b. COUNTY   |  |   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  |  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br>1154 N. Calhoun Street  |  |   |  | 10f. ZIP CODE<br>21217   |  |  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black  |  |   |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (8-12) College (1-4 or 5 +)  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Groom   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Race Track  |  |   |  | 17. FATHER'S NAME (First, Middle, Last)<br>Samuel J. Wilson, Sr.   |  |  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Elsie Quickley   |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br>Lena Quickley   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>813 Wilbert Avenue Baltimore, Md 21212  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Zion AME Church Cem.  |  |   |  | 20c. LOCATION — City or Town, State<br>Long Green Maryland   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Gray Hume  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>1701 McCulloh St.<br>Chatman-Harris F/H Baltimore, Md 21217   |  |   |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. TERMINAL HEAD + NECK CANCER<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |
| 26a. DATE OF INJURY (Month, Day, Year)  |  |  |  | 26b. TIME OF INJURY<br>M  |  |   |  | 26c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 26d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |  |  | 28. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>A. Goldstone M.D.  |  |  |  | 29c. LICENSE NUMBER<br>D39723   |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br>10/1/90   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>A. GOLDSTONE 600 N. WOLFE ST. CARNEGIE 400 BALTO, MD 21218   |  |  |  | 31. DATE FILED (Month, Day, Year)<br>CT 02 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Rendell  |  |  |  |



**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

REG. NO.

90 26899

1 - FOR  
STATE  
REGISTRAR

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Curtis T. Washington, Sr   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-27-90   |  | 3. TIME OF DEATH<br>5:22PM   |  |
| 4. SOCIAL SECURITY NUMBER<br>215-86-7941   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>19 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>7-29-1971  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Md   |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>UNIVERSITY Hospital   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City  |  |
| 9c. COUNTY OF DEATH  |  |   |  | 10a. STATE<br>Md  |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 10e. STREET AND NUMBER<br>1804 N. Bethel Street  |  |   |  | 10f. ZIP CODE<br>21213  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U S A   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Tommy Washington, Sr  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Ida Waters   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Renea Washington   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1804 N. Bethel Street Baltimore, Md 21213  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Holly Hill Cemetery   |  | 20c. LOCATION — City or Town, State<br>Chase, Md  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Glynn B. Scott</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>March F/H West<br>4300 Wabash Avenue  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gunshot wounds to chest and left thigh<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br>9-27-90  |  | 28b. TIME OF INJURY<br>4:50PM  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>Subject shot   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>Street  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>900 Argyle Avenue, Baltimore, MD |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Mario F. Golle, Jr.</i>  |  |   |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-28-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARIO F. GOLLE, JR., MD 111 Penn Street, Baltimore, MD 21201  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as a transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

DHMH-16 Rev 1/89

**DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146**

Handwritten text, possibly a signature or name, located in the upper middle section of the page.

Handwritten text, possibly a date or short note, located in the middle right section of the page.

Handwritten text, possibly a signature or name, located in the lower middle section of the page.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26901

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>EMIL WILLIAM WIENECKE, JR   |  |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 30 YEAR 90  |  | 3. TIME OF DEATH<br>1:45 a M   |  |
| 4. SOCIAL SECURITY NUMBER<br>213-09-5816  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>74 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>7/17/16                                    |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>VA MEDICAL CENTER   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>FT HOWARD  |  | 9c. COUNTY OF DEATH<br>BALTIMORE   |  |
| 10a. STATE<br>MARYLAND  |  |  |  | 10b. COUNTY<br>BALTIMORE  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>101 CENTER PLACE  |  |  |  | 10f. ZIP CODE<br>21222  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW II  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>CARPENTER   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>EMIL WILLIAM WIENECKE, SR  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MARY SHOVER  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>CLINICAL RECORDS  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>VA MEDICAL CENTER, FT HOWARD, MARYLAND 21052   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b.<br>Druid Ridge Cemetery<br>Greenmount Crematory   |  | 20c. LOCATION — City or Town, State<br>Balto., Md.  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Robert S. Asch</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Bradley-Ashton Funeral Home, INC.<br>2134 Willow Spring Rd. Dundalk, Md. 21222  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |  | Approximate<br>Interval Between<br>Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CONGESTIVE HEART FAILURE<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. RENAL FAILURE<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| c. GANGRENE OF TOES LEFT FOOT<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| d.  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>PERIPHERAL VASCULAR DISEASE<br>CHRONIC ORGANIC BRAIN SYNDROME   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>John Davidson-Randall</i>   |  |  |  | 29c. LICENSE NUMBER<br>D30528   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/30/90                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DR. M. BALA DUGGIRALA, MD. VA MEDICAL CENTER, FORT HOWARD, MARYLAND 21052  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 02 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or funeral home.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26902

|   |  |  |  |   |  |  |   |   |  |  |  |
|---|--|--|--|---|--|--|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MURIEL H. WOOLSEY   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9 / 27 / 90   |  | 3. TIME OF DEATH<br>10:47 AM   |   |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>216-14-0277  |  | 6. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>69 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>09-04-1921                                    |   | 8. BIRTHPLACE (State or Foreign Country)<br>England |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Franklin Square Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Rossville  |  |  | 9c. COUNTY OF DEATH<br>Baltimore County   |   |  |  |  |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Baltimore   |  | 10c. CITY, TOWN OR LOCATION<br>Dundalk  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |   |  |  |  |
| 10e. STREET AND NUMBER<br>7203 German Hill Road   |  |  |  | 10f. ZIP CODE<br>21222  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White  |   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12th Grade  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Payroll Clerk  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Western Electric  |  |  |   |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Ernest Handslip  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Florence Parkinson   |  |  |   |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Neil S. Woolsey   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>7203 German Hill Road, Baltimore, MD 21222   |  |  |   |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Oak Lawn Cemetery 10/01/90   |  | 20c. LOCATION — City or Town, State<br>Baltimore, MD  |  |  |   |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Chark W. Fisher  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Duda-Ruck Funeral Home of Dundalk, Inc.<br>7922 Wise Avenue, Baltimore, MD 21222  |  |  |   |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic Heart Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE NOW INJURY OCCURRED                   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>W. S. H. DO   |  |   |  | 29c. LICENSE NUMBER<br>N/A   |   | 29d. DATE SIGNED (Month, Day, Year)<br>9/27/90      |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Marc Hestle M.D. 9000 Franklin Square Drive Baltimore Maryland 21237   |  |  |  |   |  |  |   |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 2 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Rendall  |  |  |   |   |  |  |  |

22. 03



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26903

|   |  |  |  |   |  |   |   |  |  |   |   |  |
|---|--|--|--|---|--|---|---|--|--|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ZELLINE E. AVERY</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>28</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>8:00 A M</b>   |   |  |  |   |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-44-0490</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>47</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>8/25/43</b>                                    |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD.</b> |  |   |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Seton Hill Manor Nursing Home</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  |   | 9c. COUNTY OF DEATH   |  |  |   |   |  |
| 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE, CITY</b>   |  |   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |  |   |   |  |
| 10e. STREET AND NUMBER<br><b>2441 LAURETTA AVE.</b>   |  |  |  | 10f. ZIP CODE<br><b>21223</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |  |  |   |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                               |  |  |   |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>DISABLED</b>             |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |   |  |  |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ABRAHAM MILES</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>CARRIE ROSS</b>   |  |   |   |  |  |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MICHELLE AVERY</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2441 LAURETTA AVE. - BALTIMORE, MD. 21223</b>   |  |   |   |  |  |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ARBUTUS MEMORIAL PARK</b>                                       |  |   | 20c. LOCATION — City or Town, State<br><b>ARBUTUS, MD.</b> |   |   |  |  |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Vanessa Coad</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>  |  |   |   |  |  |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>pneumonia</b><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>mycobacter. in acute complex</b><br>c. <b>acquired immune deficiency syndrome</b> |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>5 days</b><br><b>10 mos</b><br><b>1 year</b>       |  |  |   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hx of candida esophagitis</b><br><b>Hx of Myocardial Infarction</b><br><b>Hx of Pneumocystis Pneumonia</b>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | HOSPITAL:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA                          |  | OTHER:<br><input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |   |  |  |   |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED                      |  |   |   |  |
| 26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |  |   |   |  |
| 29a. CERTIFIER<br>(Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>David Thomas</b>  |  | 29c. LICENSE NUMBER<br><b>J4334</b>  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/28/90</b> |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>David Thomas MD Infectious Disease Service, Johns Hopkins Hospital</b>  |  |  |  |   |  |   | 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>   |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b> |   |  |

4-20-73

1/20

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |                                   |  | REG. NO.  |  | 90 26904                          |  |
|---|--|--|--|--|--|-----------------------------------|--|---|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |  |  | 2. DATE OF DEATH   |  |                                   |  | 3. TIME OF DEATH  |  |                                   |  |
| Mnawar (Menawar)  |  |  |  | 10 02 DAY YEAR   |  |                                   |  | 7:45 AM   |  |                                   |  |
| ARSHALUYS ARMENIAN  |  |  |  |  |  |                                   |  |   |  |                                   |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX   |  | 6. AGE (In yrs. last birthday)   |  | 7. DATE OF BIRTH                  |  | 8. BIRTHPLACE (State or Foreign Country)  |  |                                   |  |
| N/A   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 76 YRS.  |  | 01 01 14                          |  | Turkey  |  |                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |                                   |  | 9c. COUNTY OF DEATH   |  |                                   |  |
| GREATER BALTIMORE MEDICAL CENTER  |  |  |  | TOWSON   |  |                                   |  | BALTIMORE   |  |                                   |  |
| 10a. STATE  |  |  |  | 10b. COUNTY  |  |                                   |  | 10c. CITY, TOWN OR LOCATION   |  |                                   |  |
| MD  |  |  |  | BALTIMORE  |  |                                   |  | TIMONIUM  |  |                                   |  |
| 10d. INSIDE CITY LIMITS?  |  |  |  | 10e. STREET AND NUMBER   |  |                                   |  | 10f. ZIP CODE   |  |                                   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 308 KIMRICK PLACE  |  |                                   |  | 21093   |  |                                   |  |
| 11. MARITAL STATUS  |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |  |                                   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?  |  |                                   |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES          |  |                                   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |                                   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) |  |                                   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |                                   |  |
| Elementary/Secondary (0-12) College (1-4 or 5+)   |  |  |  | N/A  |  |                                   |  | N/A   |  |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |                                   |  |   |  |                                   |  |
| Ghazaros Oghlie   |  |  |  | Aroussiak Fermanian  |  |                                   |  |   |  |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)              |  |                                   |  |   |  |                                   |  |
| Garabed K. Armenian   |  |  |  | 6006 Balsam Dr. McLean Va. 22101   |  |                                   |  |   |  |                                   |  |
| 20a. METHOD OF DISPOSITION  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)                                     |  |                                   |  | 20c. LOCATION — City or Town, State   |  |                                   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)                                    |  |  |  | Arlington Cemetery   |  |                                   |  | Upper Darby, Pennsylvania   |  |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |  |  | 22. NAME AND ADDRESS OF FACILITY   |  |                                   |  |   |  |                                   |  |
| Dennis S. Xenakis   |  |  |  | Mitchell-Wiedefeld Home 6500 York Rd 21212   |  |                                   |  |   |  |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |  |  |                                   |  | Approximate Interval Between Onset and Death  |  |                                   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |  |  |  |  |                                   |  |   |  |                                   |  |
| a. VENTRICULAR FIBRILLATION   |  |  |  |  |  |                                   |  |   |  |                                   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |                                   |  |   |  |                                   |  |
| b. CARDIAC PULMONARY EDEMA  |  |  |  |  |  |                                   |  |   |  |                                   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |  |  |                                   |  |   |  |                                   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |                                   |  |   |  |                                   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |                                   |  |   |  |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |  |  |                                   |  | 24a. WAS AN AUTOPSY PERFORMED?  |  |                                   |  |
| AORTIC STENOSIS   |  |  |  |  |  |                                   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  |  |  |  |  |                                   |  | 26. PLACE OF DEATH (Check only one)   |  |                                   |  |
| 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |                                   |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                   |  |
| 27. MANNER OF DEATH   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY               |  | 28c. INJURY AT WORK?  |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |
| 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined |  |  |  |  |  | M                                 |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |                                   |  |
| 29a. CERTIFIER (Check only one)   |  |  |  | 29b. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                     |  | 29c. LICENSE NUMBER               |  | 29d. DATE SIGNED (Month, Day, Year)   |  |                                   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  | D16189                            |  | 10/2/90   |  |                                   |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |                                   |  |   |  |                                   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)                        |  | 31. DATE FILED (Month, Day, Year) |  | 32. REGISTRAR'S SIGNATURE   |  |                                   |  |
| [Signature]   |  |  |  | CICKARIKAN - 6565 N. Chalk St - Towson 21204   |  | OCT 03 1990                       |  | [Signature]   |  |                                   |  |



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mason Burrell</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>30</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>4:52 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-30-1363</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>55</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>5-6-35</b>                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>2607 W. Fairmount Ave.</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>MD</b>  |  |   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE, CITY</b>                        |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>2607 W. FAIRMOUNT AVE.</b>   |  |  |  |
| 10f. ZIP CODE<br><b>21223</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>12th</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>CONSTRUCTION</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>RAYMOND BURRELL</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>REBA</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>RUTH WILLIAMS</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2607 W. FAIRMOUNT AVE. - BALTIMORE, MD. 21223</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GARRISON FOREST VET. CEM.</b>  |  | 20c. LOCATION — City or Town, State<br><b>OWINGS MILLS, MD.</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Vanessa Good</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Ann M. Dixon, M.D.</i>   |
| 29c. LICENSE NUMBER<br><b>OCME</b>   |  |   |  |   |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/30/90</b>  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Ann M. Dixon, M.D. 111 Penn St. Baltimore, Md. 21201</b>   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>  |  |   |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 3146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26906

1 - FOR  
STATE  
REGISTRAR

|   |  |   |  |  |  |   |  |  |  |  |  |  |  |
|---|--|---|--|--|--|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Geraldine H. Basore   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-27-90  |  | 3. TIME OF DEATH<br>2:00AM M  |  |  |  |  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>235-70-1582  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>68 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>APR. 27, 1922             |  | 8. BIRTHPLACE (State or Foreign Country)<br>WEST VIRGINIA                          |  |  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Washington County General Hospital  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Hagerstown  |  |   | 9c. COUNTY OF DEATH<br>Washington County |  |  |  |  |  |  |
| RESIDENCE OF DECEDENT   |  |   |  | 10a. STATE<br>WV   |  | 10b. COUNTY<br>BERKELEY   |  | 10c. CITY, TOWN OR LOCATION<br>HEDGESVILLE   |  |  |  |  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  | 10e. STREET AND NUMBER<br>RT. 4, BOX 577   |  | 10f. ZIP CODE<br>25427  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE |  |  |  |  |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>HOMEMAKER  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>HOME   |  |   |  |  |  |  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>W. W. DICK   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>LAFUANN FRENCH  |  |   |  |  |  |  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>WILLIAM R. CLEM   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>POBOX 925, BERKELEY SPRINGS, WV 25411   |  |   |  |  |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>PROVIDENCE CEMETERY   |  | 20c. LOCATION — City or Town, State<br>RFD, HEDGESVILLE, WV  |  |   |  |  |  |  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Charles M. Brown   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>BROWN FUNERAL HOME, 327 W. KING ST.<br>POBOX 821, MARTINSBURG, WV 25401  |  |   |  |  |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic cardiovascular disease<br>e. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death                                       |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>XXX YES 2 <input type="checkbox"/> NO<br>PARTIAL |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>XXX YES 2 <input type="checkbox"/> NO |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>XXX YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> OOA<br>OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)                              |  | 28b. TIME OF INJURY<br>M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                                 |  |  |  |
| 28d. DESCRIBE NOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Mario F. Golle, Jr., MD                   |  | 29c. LICENSE NUMBER<br>OCME  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-28-90 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)<br>MARIO F. GOLLE, JR., MD 111 Penn Street, Baltimore, MD 21201   |  |   |  |  |  |   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |  |  |   |  |  |  |  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 3146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 90 26907

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Frank CLARK JR.</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> / DAY <b>28</b> / YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>5:30</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>243-40-3534</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>61</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>01/30/29</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>N.C.</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Deaton Hosp &amp; Medical Center</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balto-Md</b>  |  |
| 9c. COUNTY OF DEATH  |  |  |  | 10a. STATE<br><b>MD</b>   |  |   |  |
| 10b. COUNTY  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE, CITY</b>   |  |   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>146 S. WILLIARD ST.</b>  |  |   |  |
| 10f. ZIP CODE<br><b>21223</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                               |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>5th</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>CEMENT/DRYWALL</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>FRANK CLARK SR.</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SADIE</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>INEZ L. FULTON</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2701 WOODSDALE AVE.-BALTIMORE, MD 21214</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ARBUTUS MEMORIAL PK.</b>  |  | 20c. LOCATION — City or Town, State<br><b>ARBUTUS, MD.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Vanessa Coad</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Prostatic cancer</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>16 months</b>                                      |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>s/p radiation, s/p bilateral orchiectomy and TURP, (R) metastatic</b>   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO           |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Timothy J. Keane</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D37458</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/28/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1000



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene after burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

90 26908

REG. NO.

|  |  |   |   |  |   |  |  |                                   |  |   |
|--|--|---|---|--|---|--|--|-----------------------------------|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>WILLIAM P. COOKERLY  |  |   |   |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>10 1 90        |  | 3. TIME OF DEATH<br>7 15 A M      |  |   |
| 4. SOCIAL SECURITY NUMBER<br>216-07-5320   |  | 5. SEX<br>X M 2 F   | 6. AGE (In yrs. last birthday)<br>85 YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br>10-22-04  |   | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland |  |                                   |  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>CHURCH HOSPITAL CORPORATION  |  |   |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY  |   |  | 9c. COUNTY OF DEATH  |                                   |  |   |
| RESIDENCE OF DECEDENT  |  |   |   |  |   |  |  |                                   |  |   |
| 10a. STATE<br>MD.<br>Maryland  |  | 10b. COUNTY<br>Harford  |   | 10c. CITY, TOWN OR LOCATION<br><del>BALTIMORE</del> FALLSTON   |   |  | 10d. INSIDE CITY LIMITS?<br>1 YES 2 X NO                         |                                   |  |   |
| 10e. STREET AND NUMBER<br>3111 WINCHESTER WAY  |  |   |   | 10f. ZIP CODE<br>21047   |   | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A               |  |                                   |  |   |
| 11. MARITAL STATUS<br>1 Never Married 2 Married<br>3 X Widowed 4 Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO<br>IF YES, GIVE WAR OR DATES   |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 YES 2 X NO Specify: |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White |                                   |  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12 yr's  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Electrician                 |   | 16b. KIND OF BUSINESS/INDUSTRY   |   |  |  |                                   |  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Francis Cookerly  |  |   |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Gertrude Steiger  |   |  |  |                                   |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Evelyn M. Yankowski   |  |   |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same as #10 E                           |   |  |  |                                   |  |   |
| 20a. METHOD OF DISPOSITION<br>1 X Burial 2 Cremation 3 Removal from State<br>4 Donation 5 Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Gardens Of Faith 10/4/90  |   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Md. |  |  |                                   |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Paul L. Hartsock, Jr.<br><i>Paul L. Hartsock, Jr.</i>   |  |   |   | 22. NAME AND ADDRESS OF FACILITY<br>Baltimore, Md. 21214<br>Leonard J. Ruck, Inc. 5305 Harford Rd.                                       |   |  |  |                                   |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiorespiratory failure</i><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF): <i>Cardiorespiratory failure</i><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |   |  |   |  |  |                                   | Approximate Interval Between Onset and Death |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |   |  |  |                                   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 YES 2 NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 YES 2 NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA<br>OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) |   |  |   |  |  |                                   |  |   |
| 27. MANNER OF DEATH<br>1 Natural 5 Pending Investigation<br>2 Accident 6 Suicide<br>3 Suicide 8 Could not be determined<br>4 Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M   |   | 28c. INJURY AT WORK?<br>1 YES 2 NO                   |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |   |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |  |                                   |  |   |
| 29a. CERTIFIER (Check only one)<br>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |   |  |   |  |  |                                   |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>R. Bakhair</i> M.D.  |  |   |   | 29c. LICENSE NUMBER<br>D-26594   |   | 29d. DATE SIGNED (Month, Day, Year)<br>10/1/90       |  |                                   |  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DR. RIAZ BAKHAIR M.D. 10 WARREN RD. COKEYSVILL, MD. 21030   |  |   |   |  |   |  |  |                                   |  |   |
| 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990<br>REGISTRAR'S SIGNATURE<br><i>J. Davidson-Randall</i>  |  |   |   |  |   |  |  |                                   |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed with 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26909

|  |  |  |  |   |  |  |   |   |   |   |  |
|--|--|--|--|---|--|--|---|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOHN J. CARTER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>1</b> YEAR <b>1990</b>   |  | 3. TIME OF DEATH<br><b>12:30 PM</b>                    |   |   |   |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>112-05-2968</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.  |  | 7. DATE OF BIRTH<br>Month Day Year<br><b>1-26-1909</b> |   | 8. BIRTHPLACE (State or Foreign)<br><b>MARYLAND</b>   |   |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>EASTPOINT NURSING HOME</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                 |   |   |   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  |  |  | 10b. COUNTY<br><b>BALTIMORE</b>   |  |  | 10c. CITY, TOWN OR LOCATION<br><b>EDGEMERE</b>                          |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br><b>9104 NORTH POINT ROAD</b>   |  |  |  | 10f. ZIP CODE<br><b>21219</b>   |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                          |   |   |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |   |   |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8TH GRADE</b> College (1-4 or 5+) <b>N/A</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>SHIPPING CLERK</b>   |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>GEORGE M. KIPP &amp; SON</b>       |   |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOHN CARTER</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>FLORENCE LYNCH</b>  |  |  |   |   |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MILDRED R. CARTER</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9104 NORTH POINT ROAD BALTIMORE, MD 21219</b>   |  |  |   |   |   |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>LOUDON PARK CEMETERY 10-4-1990</b>   |  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>       |   |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Chas W. Fisher</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DUDA-RUCK FUNERAL HOME OF DUNDALK, INC.<br/>7922 WISE AVENUE DUNDALK, MD 21222</b>   |  |  |   |   |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardio-Respiratory arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Angiosteny heart failure</b><br><b>ASCVD</b><br><br>Approximate interval Between Onset and Death<br><b>years</b> |  |  |  |   |  |  |   |   |   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic atrial fibrillation</b><br><b>Severe dementia</b>   |  |  |  |   |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |   |   |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>                        |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                      |   | 28d. DESCRIBE HOW INJURY OCCURED  |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                          |   |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>R. Matos, M.D. Att. Physician</i>   |  |  |   | 29c. LICENSE NUMBER<br><b>D14618</b>  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>10/2/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BIENVENIDO R. MATOS, M.D. 21 Cranberry Rd. Cockeysville Md. 21030</b>  |  |  |  |   |  |  |   |   |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>   |  |  |   |   |   |   |  |

1. The first part of the paper is devoted to a discussion of the

2. The second part of the paper is devoted to a discussion of the

3. The third part of the paper is devoted to a discussion of the

4. The fourth part of the paper is devoted to a discussion of the

5. The fifth part of the paper is devoted to a discussion of the

6. The sixth part of the paper is devoted to a discussion of the

7. The seventh part of the paper is devoted to a discussion of the

8. The eighth part of the paper is devoted to a discussion of the

9. The ninth part of the paper is devoted to a discussion of the

10. The tenth part of the paper is devoted to a discussion of the

11. The eleventh part of the paper is devoted to a discussion of the

12. The twelfth part of the paper is devoted to a discussion of the

13. The thirteenth part of the paper is devoted to a discussion of the

14. The fourteenth part of the paper is devoted to a discussion of the

15. The fifteenth part of the paper is devoted to a discussion of the

16. The sixteenth part of the paper is devoted to a discussion of the

17. The seventeenth part of the paper is devoted to a discussion of the

18. The eighteenth part of the paper is devoted to a discussion of the

19. The nineteenth part of the paper is devoted to a discussion of the

20. The twentieth part of the paper is devoted to a discussion of the



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26910

|   |  |   |  |   |  |  |  |  |   |  |
|---|--|---|--|---|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>THELMA IRENE CHRISTIAN  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>10 01 90  |  | 3. TIME OF DEATH<br>650 A M  |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>085-07-4046  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>72 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Oct. 17, 1917                              |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Harbor Hospital Center  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore  |  |  | 9c. COUNTY OF DEATH  |  |   |  |
| 10a. STATE<br>Md  |  | 10b. COUNTY<br>Baltimore  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br>2204 Alletta Avenue   |  |   |  | 10f. ZIP CODE<br>21227  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White                            |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>10th Grade   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Lenard Michaels  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Bostian   |  |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>William R. Wall, Sr.  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1234 Buckhorn Road, Sykesville, Md 21784   |  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Meadow Ridge Memorial Park  |  |   | 20c. LOCATION — City or Town, State<br>Baltimore |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>M. Keaf Coleman  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Hubbard Funeral Home Inc.<br>4107 Wilkens Avenue, Baltimore, MD. 21229  |  |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic breast carcinoma<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>IRON overload anemia |  |   |  |   |  |  | Approximate interval Between Onset and Death   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 25. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Resurgence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                    |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>H/O  |  |   |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br>10-01-90      |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>CLAUDIO ZAWITKOWSKI, HARBOR HOSPITAL CTR, 301 S. HANOVER ST. BALTIMORE, MD 21230   |  |   |  |   |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |  |  |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for registration, burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 90 26911

|   |  |  |                                  |  |  |   |  |   |   |   |  |   |  |
|---|--|--|----------------------------------|--|--|---|--|---|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HELEN G. COHEN</b>   |  |  |                                  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>22</b> YEAR <b>90</b>  |  |   |  | 3. TIME OF DEATH<br><b>530 AM</b>   |   |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215 327815</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |                                  | 8. AGE (In yrs. last birthday)<br><b>87</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>06 01 03</b>                                      |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>POLAND</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Fairland Nursing Home</b>  |  |  |                                  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Silver Spring Md.</b>   |  |   | 9c. COUNTY OF DEATH<br><b>Mont.</b>   |   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  |  | 10b. COUNTY<br><b>MONTGOMERY</b> |  |  | 10c. CITY, TOWN OR LOCATION<br><b>SILVER SPRING</b>   |  |   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>1731 BRIGGS CHANEY RD.</b>   |  |  |                                  |  |  | 10f. ZIP CODE<br><b>20905</b>   |  |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |                                  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                               |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  |  |                                  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>HOUSEWIFE</b>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>AT HOME</b>  |   |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>LOUIS GROSS</b>   |  |  |                                  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ESTHER UNKNOWN</b>  |  |   |   |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DR. SANFORD HOCHMAN</b>  |  |  |                                  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1731 BRIGGS CHANEY RD. SILVER SPRING, MD 20905</b>  |  |   |   |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |                                  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>AITZ CHAIM</b>  |  |   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>                                 |   |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |                                  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |   |   |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Advanced Carcinoma Oropharynx</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Cachexia of Metastatic Origin</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>Malnutrition + Dehydration</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |                                  |  |  |   |  |   |   | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |                                  |  |  |   |  |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |                                  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  |  |                                  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 28d. DESCRIBE NOW INJURY OCCURRED   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |                                  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |                                  |  |  |   |  |   |   |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |                                  |  |  | 29c. LICENSE NUMBER<br><b>D13171</b>  |  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-23-90</b>   |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>BE Mameguala MD 14201 Laurel Park &amp; Laurel MD 20707</b>   |  |  |                                  |  |  |   |  |   |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>   |  |  |                                  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |   |   |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>RICHARD CZECH  |  |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 30 YEAR 90  |  | 3. TIME OF DEATH<br>P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>212-23-6970   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>33 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>6-27-57  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>POLAND   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>2706 Dunwall Court, Apt. B   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore  |  | 9c. COUNTY OF DEATH<br>Baltimore  |  |
| 10a. STATE<br>MARYLAND   |  |  |  | 10b. COUNTY<br>BALTIMORE  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br>3127 ELLIOTT STREET   |  |   |  |
| 10f. ZIP CODE<br>21224   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE                             |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>UNEMPLOYED   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>ZIEGFRIED CZECH   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>MRS. HELEN CZECH   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3127 ELLIOTT ST. BALTIMORE, MARYLAND 21224   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>ST. STANISLAUS CEMETERY  |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MARYLAND  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Raymond L. Haczorowski</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>KACZOROWSKI FUNERAL HOME<br>2525 FLEET ST. BALTO. MD. 21224   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Contact Gunshot Wound of Head and Neck<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>(Head Only)   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br>9-30-90  |  | 28b. TIME OF INJURY<br>1:10 P M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br>Subject shot self   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>home   |  |   |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>2706 Dunwall Court, Apt. B, Baltimore County, MD   |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Ann M. Dixon</i>   |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>10-1-90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ann M. Dixon, M.D., Deputy Chief 111 Penn Street, Baltimore, MD 21201 v1  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |   |  |

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other immediate event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed with 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for vital, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26913

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Moss W. Dodson  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>16 1 90   |  | 3. TIME OF DEATH<br>0:58 A.M.   |   |
| 4. SOCIAL SECURITY NUMBER<br>213-38-6198  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>85 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>April 15, 1905   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Pickersgill Home  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Towson   |  | 9c. COUNTY OF DEATH<br>Baltimore  |   |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |   |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY<br>Baltimore   |  | 10c. CITY, TOWN OR LOCATION<br>Cockeysville   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>604 Knollcrest Place  |  |  |  | 10f. ZIP CODE<br>21030  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT use retired.)<br>Homemaker   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Alfred Wells, Sr.  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary Jane Medforth   |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Pickersgill Home  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>615 Chestnut Ave. Towson, Maryland 21204   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Gardens of Faith Cem. 10-4-90  |  | 20c. LOCATION — City or Town, State<br>Overlea, Maryland  |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Wallace S. Brooks, Jr.   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Ruck Towson Funeral Home, Inc.<br>1050 York Road, Towson, Md. 21204   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ventricular tachycardia<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Cerebral hypoxia<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. CVA<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. ASD<br>Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
|   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
|   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Pharis N. Pharis MD  |  |  |  | 29c. LICENSE NUMBER<br>D36908   |  | 29d. DATE SIGNED (Month, Day, Year)<br>10/1/90  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |   |   |

61 55 00

C. A. 100 3

100 100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

2



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

90 26914

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>James Edward Ewig</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>26</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>12:30 P M</b>   |   |
| 4. SOCIAL SECURITY NUMBER<br><b>176-36-7416</b>  |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>46</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 28, 1944</b>  |   |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Joseph's Hospital</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>   |   |
| 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>  |   |
| 10c. CITY, TOWN OR LOCATION<br><b>Cockeysville</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>26 Bosley Avenue</b>  |   |
| 10f. ZIP CODE<br><b>21030</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced |   |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Physiology Professor</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>College</b>   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Robert E. Ewig</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jean Wright</b>   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Robert E. Ewig</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>161 Demar Blvd., Canonsburg, PA 15317</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Forrest Lawn Gardens</b>   |  | 20c. LOCATION — City or Town, State<br><b>McMurray, PA</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Richard S. Maffell</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>J.J. Hartenstein Mortuary, Inc.<br/>24 Second St., New Freedom, PA 17349</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Hypertensive arteriosclerotic cardiovascular disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |  |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Frank J. Peretti</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/27/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Frank J. Peretti, M.D. - Assistant 111 Penn St. Balto, MD</b>  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

90 26915

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>IDA MAE FRANCE</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>01</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>0520 A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-10-4900</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Aug. 13, 1907</b>                       |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Catonsville</b>                                    |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>5513 N. Medwick Garth</b>   |  |  |  | 10f. ZIP CODE<br><b>21228</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b></b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Alvy Keyser</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Zepha Belle Hamerick</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. Richard Anderson</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2 Forest Drive, Catonsville, Maryland 21228</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>Entombment</b>   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Crest Lawn Mausoleum</b>  |  | 20c. LOCATION — City or Town, State<br><b>10/4/90</b><br><b>Howard County, Maryland</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE PROVIDER<br><i>Michael Dick</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Leonard J. Ruck, Inc. 5305 Harford Road 21214</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIO PULMONARY FAILURE</b><br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>ACUTE LEUKEMIA</b> </div> <div style="width: 35%; border-left: 1px solid black; padding-left: 5px;">                 Approximate Interval Between Onset and Death             </div> </div> |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Robert Adams M.D.</i>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>10/11/90</b>                               |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>J. Davidson-Randall</i>   |  |  |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the attending physician within 24 hours after death. Pages 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for filing. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26916

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Dorothy A. Foos   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9/28/90  |  | 3. TIME OF DEATH<br>9:50 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>218-22-4698  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>83 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>4/6/07   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Union Memorial Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City  |  |
| 9c. COUNTY OF DEATH   |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>5809 Willowton Rd.   |  |
| 10f. ZIP CODE<br>21239  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 yrs.<br>College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Clerk                           |  |
| 16b. KIND OF BUSINESS/INDUSTRY<br>HECHTs  |  | 17. FATHER'S NAME (First, Middle, Last)<br>J. Howard Norris  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Margaret C. Hebis   |  | 19a. INFORMANT'S NAME (Type/Print)<br>James H. Norris Jr.  |  |
| 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>311 Hollyberry Rd. Severna Pk, Md. 21146   |  | 20. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>New Cathedral Cemetery   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Md.  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Robert M. Kratz  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Mitchell-Wiedefeld Home<br>6500 York Rd. 21212   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. UREMIA<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. End Stage Congestive Heart Failure<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. Dilated Cardiomyopathy<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  | Approximate interval between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Urinary Tract Infection<br>COPD<br>Multi System Failure   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                            |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>J. Elizabeth Dennis Intern   |  |  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/28/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>J. ELIZABETH DENNIS UMH  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |  |  |

Page 1

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26917

|   |  |  |  |  |  |   |  |
|---|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HYMAN R. FRAME</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPT. 29 90</b>   |  | 3. TIME OF DEATH<br><b>2 12A M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-03-9299</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>88</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>DEC. 5, 1901</b>                               |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                                     |  |
| 9c. COUNTY OF DEATH   |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  |   |  |
| 10b. COUNTY<br><b>BALTIMORE</b>   |  |  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  |   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>3901 SEVEN MILE LA., APT. G-3</b>   |  |   |  |
| 10f. ZIP CODE<br><b>21208</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>College</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>SALESMAN</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>INSTALLMENT</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>SAMUEL FRAME</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>RACY NEVINS</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MRS. RUTH FRAME</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3901 SEVEN MILE LA., APT. G-3 BALTO., MD 21208</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>HEBREW FRIENDSHIP</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Possible aortic aneurysm rupture</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br><b>b. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>c. DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> |  |  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Coronary artery disease</b>  |  |  |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i> MD  |  |  |  | 29c. LICENSE NUMBER<br><b>038970</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/29/90</b>                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Gregory Buser 131 W. Barre St Balto MD 21201</b>  |  |  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>9/29/90</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for filing, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |   | 90 26918  |  |  |  |                                   |  |
|---|--|--|--|---|--|---|---|---|--|--|--|-----------------------------------|--|
| CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |   |   |   |  |  |  |                                   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Fanny Goldberg</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>27</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>2:25 A.M.</b>                                    |   |   |  |  |  |                                   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-03-1695</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS. |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>8-21-1907</b> |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b> |   |  |  |  |                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>BALTIMORE COUNTY GEN. HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>RANDALLSTOWN</b>  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>                                 |   |   |  |  |  |                                   |  |
| 10a. STATE<br><b>MARYLAND</b>   |  |  |  | 10b. COUNTY<br><b>BALTIMORE</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>                         |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |  |  |                                   |  |
| 10e. STREET AND NUMBER<br><b>1332 CHURCH HILL DR.</b>   |  |  |  | 10f. ZIP CODE<br><b>21208</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                             |   |   |  |  |  |                                   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR OATHS  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |   |   |  |  |  |                                   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>12</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>BOOKKEEPER</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>ACCOUNTING</b>   |  |   |   |   |  |  |  |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>UNKNOWN FEINSTEIN</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ZEVA (UNKNOWN)</b>  |  |   |   |   |  |  |  |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>PHILIP GOLDBERG</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4010 SANLEE RD. RANDALLSTOWN, MD 21133</b>  |  |   |   |   |  |  |  |                                   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>ARLINGTON (CHIZUK AMUNO)</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>   |  |   |   |   |  |  |  |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Joel D Lewis</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |   |   |   |  |  |  |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Ischemic cardiomyopathy</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   |   | Approximate Interval Between Onset and Death  |  |  |  |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>① Diabetes mellitus</b><br><b>② Atherosclerotic peripheral vascular disease</b>  |  |  |  |   |  |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospital Baltimore County</b> |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)                                  |   | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO          |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Michael D. ... M.D.</b>  |  | 29c. LICENSE NUMBER<br><b>D38882</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/27/90</b>                   |   |   |  |  |  |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>KHALID K. AL-TALIB, Baltimore County General Hospital</b>   |  |  |  |   |  |   |   |   |  |  |  |                                   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Gina Davidson-Randall</b>   |  |   |   |   |  |  |  |                                   |  |

01112 00

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic agent, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 90 26919


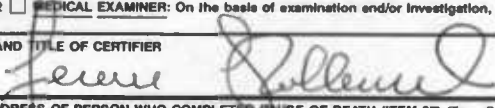
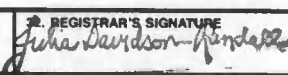
|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>H. HARRY GREENBERG</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCT. 1, 1990</b>  |  | 3. TIME OF DEATH<br><b>6:30 A. M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-24-0580</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>90</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>MAR. 21, 1900</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>RUSSIA</b>  |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>3903 SEVEN MILE LA., APT. 1A</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>  |  |
| 9c. COUNTY OF DEATH  |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>3903 SEVEN MILE LA., APT. 1-A</b>   |  |
| 10f. ZIP CODE<br><b>21208</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary (0-12) <b>12</b> College (1-4 or 5+)  |  |  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>BUTCHER</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>FOOD</b>  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>SAMUEL GREENBERG</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SARLIE NODDLEMAN</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MRS. SANDRA LEVINE</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9003 WINANDS RD. OWINGS MILLS, MD 21117</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BETH TFILOH</b>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>  |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Ellen Levine</i>   |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., D 21215</b>  |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br><b>Cancer of prostate with Metastasis</b><br><b>DUE TO (OR AS A CONSEQUENCE OF):</b><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br><b>Underlying Cause: Chronic Disease</b> |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>28b. TIME OF INJURY M</b><br><b>28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b><br><b>28d. DESCRIBE HOW INJURY OCCURRED</b><br><b>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)</b><br><b>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</b>   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. Davidson-Randall</i>  |  |  |  |
| 29c. LICENSE NUMBER<br><b>108029</b>   |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>10/1/90</b>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  | 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>  |  |  |  |
| 32. REGISTRAR'S SIGNATURE<br><i>J. Davidson-Randall</i>  |  |  |  |  |  |  |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |   |  |  | 90 26920  |                     |   |  |   |  |
|--|--|--|--|---|---|--|--|---|---------------------|---|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |   |  |  |   |                     |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>MARY GREENBAUM</b>  |  |  |  |   |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>SEPT. 26, 1990</b>                          |  | 3. TIME OF DEATH<br><b>6 A M</b>                      |                     |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-28-8379</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>93</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>FEB. 28, 1897</b>   | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b> |  |  |   |                     |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>5905 WINNER AVE.</b>  |  |  |  |   |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>                              |  |   | 9c. COUNTY OF DEATH |   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  |  |  |   |   | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>       |                     | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |
| 10e. STREET AND NUMBER<br><b>5905 WINNER AVE.</b>  |  |  |  |   |   | 10f. ZIP CODE<br><b>21215</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>           |                     |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |   | 14. RACE — American Indian, Black, White, etc.<br>Specify <b>WHITE</b>               |  |   |                     |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>2</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>NURSE</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>MEDICINE</b>   |   |  |  |   |                     |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>DAVID GREENBAUM</b>  |  |  |  |   |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MOLLIE GROLLMAN</b>          |  |   |                     |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MRS. CHARLOTTE GREENE</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6313 WINNER AVE. BALTIMORE, MD 21215</b>  |   |  |  |   |                     |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CHIZUK AMUNO (ARLINGTON)</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>   |   |  |  |   |                     |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SOI, LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |   |  |  |   |                     |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. <u>Arteriosclerotic Heart Disease</u></b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. _____</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. _____</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. _____</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |   |  |  |   |                     | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>_____<br>_____   |  |  |  |   |   |  |  |   |                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO      |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |   |  |  |   |                     |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                     |                     |   |  |   |  |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |   |                     |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |   |  |  |   |                     |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  |   |   | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/26/90</b> |                     |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |   |   |  |  |   |                     |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |   |  |  |   |                     |   |  |   |  |

05-11-00



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | 90 26921  |  |   |  |
|--|--|--|--|---|--|---|--|---|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |   |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SALVATORE S. GAGLIANO</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>19</b> YEAR <b>90</b>   |  |   |  | 3. TIME OF DEATH<br><b>12:10 A M</b>  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>159-32-7561</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>52</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>            |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>8/17/38</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SINAI HOSPITAL OF BALTIMORE</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  |   |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  |   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>BALTIMORE COUNTY</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>SPARKS</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |   |  |
| 10e. STREET AND NUMBER<br><b>17 RAINFLOWER PATH</b>  |  |  |  | 10f. ZIP CODE<br><b>21152</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                         |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>SALESMAN</b>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>RETAIL BATTERY</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ANTHONY GAGLIANO</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>MILDRED NOWOTARSKI</b>  |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JANICE M. GAGLIANO</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>17 RAINFLOWER PATH SPARKS, MD. 21152</b>  |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GETHSEMANE CEMETERY</b>  |  |   |  | 20c. LOCATION — City or Town, State<br><b>READING, PA.</b>                                      |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Jeffrey S. Muckis</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MILKINS FUNERAL HOME, INC.<br/>4914 Kutztown Rd. Temple, PA. 19560</b>   |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPTIC SHOCK</b><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. <b>PNEUMONIA</b><br>c. <b>AIDS</b> |  |  |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CORONARY INSUFFICIENCY</b>  |  |  |  |   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide |  |   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  |   |  |
| 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Mark CUA MD</i>  |  |  |  |   |  |   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/19/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>MARK CUA SINAI</b>   |  |  |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>  |  |  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Anderson-Ruback</i> |  |   |  |   |  |

1925-26

1. The first part of the report deals with the general situation of the country and the progress of the work during the year. It is a summary of the work done by the various departments and a statement of the results achieved.

2. The second part of the report deals with the financial statement of the year. It shows the income and expenditure of the various departments and the balance of the accounts at the end of the year.

3. The third part of the report deals with the progress of the work in the various departments. It gives a detailed account of the work done in each department and the results achieved.

4. The fourth part of the report deals with the future prospects of the country and the work of the various departments. It gives a statement of the plans for the next year and the measures to be taken to achieve them.



**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

90 26922

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>KLIOZE GERSON KLIOZE</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>29</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>14:15</b> M  |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>78</b> YRS. |   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2-2-12</b> |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>UNION MEMORIAL HOSPITAL</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  | 9c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>PRINCE GEORGES CO.</b>   |  | 10c. CITY, TOWN OR LOCATION   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>RT #2 BOX 573 A WHITE PLAINS MD.</b>  |  |  |  | 10f. ZIP CODE   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>                      |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>12 YEARS</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>RETIRED</b>                 |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>SAMUEL KLIOZE</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>IDA LIEBFELD</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MRS. CATHERINE KLIOZE</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>SAME AS ABOVE</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>RESURRECTION CLINTON</b>  |  | 20c. LOCATION — City or Town, State<br><b>PRINCE G. CO. MD.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Przemyslaw Kaczorowski</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>KACZOROWSKI FUNERAL HOME<br/>2525 FLEET ST BALTO. MD. 21224</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>CARDIAC ARREST</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>MIOCARDIAL INFARCTION</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b>HYPERTENSION / ATHEROSCLEROSIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>15 MIN</b><br><b>13 HOUR</b>  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>FEMORO-FEMORO BYPASS GRAFT on 9/28/90</b>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | HOSPITAL:<br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA               |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
| 29a. SIGNATURE AND TITLE OF CERTIFIER<br><i>Peter Guadalupe, MD, Surg. Resident</i>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>09/29/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)<br><b>P. GUADALUPE, UMH, 201 E. UNIVERSITY PKWAY, BALTIMORE</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 3344

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Pages 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

DMMH:16 Box 1/89

05-1-60

7-10-60

10-1-60

10-1-60

10-1-60

10-1-60

10-1-60

10-1-60

10-1-60

2

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the cause of death be ascertained within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 90 26924  |  |   |  |  |  |
|---|--|---|--|--|--|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |   |  | REG. NO.   |  |   |  |   |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ALTON B. HUDNELL</b>   |  |   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCT. 2, 1990</b>               |  | 3. TIME OF DEATH<br>M                                 |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>213-07-3317</b>   |  | 5. SEX<br><b>1 M 2 F</b>  | 6. AGE (In yrs. last birthday)<br><b>83</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10-30-1906</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>N. CAROLINA</b>          |  |   |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>FRANCIS SCOTT KEY MEDICAL CENTER</b>   |  |   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>            |  | 9c. COUNTY OF DEATH                                   |  |   |  |  |  |
| 10a. STATE<br><b>MARYLAND</b>   |  |   |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>EDGEMERE</b>                          |  | 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>         |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>3014 DELMAR AVENUE</b>   |  |   |  |  |  | 10f. ZIP CODE<br><b>21219</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>        |  |   |  |  |  |
| 11. MARITAL STATUS<br><b>1 Never Married 2 X Married 3 Widowed 4 Divorced</b>   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 X NO</b><br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 X NO</b> Specify:    |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |   |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>8TH GRADE</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>ENGINEER PATAPSCO &amp; BACK RIVER RAIL ROAD</b> |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>CHARLES HUDNELL</b>   |  |   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>BETTY DEAL</b>  |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>HARRIETT P. HUDNELL</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3014 DELMAR AVENUE BALTIMORE, MD 21219</b> |  |   |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>OAK LAWN CEMETERY 10-4-1990</b>  |  |  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>       |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Chad W. Fisher</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>DUDA-RUCK FUNERAL HOME OF DUNDALK, INC. 7922 WISE AVENUE DUNDALK, MD 21222</b>                          |  |   |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardio - Pulmonary arrest</b><br><b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b><br><b>Chronic obstructive airway disease</b> |  |   |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death<br><b>months 30 yr</b> |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 NO</b>                 |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b> |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 NO</b>   |  | 25. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>              |  |  |  |   |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY M  |  | 28c. INJURY AT WORK? <b>1 YES 2 NO</b>                                  |  | 28d. DESCRIBE HOW INJURY OCCURRED                     |  |   |  |  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>   |  |   |  |  |  |   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Julia Davidson-Randall</i>  |  |   |  |  |  | 29c. LICENSE NUMBER<br><b>D18648</b>                                    |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>10/2/90</b> |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>1012 rd N. E.T. Co Baltimore MD 21224</b>   |  |   |  |  |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>   |  | 31. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |  |  |   |  |   |  |   |  |  |  |



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Robert Reginald Handy   |  |  |  | 2. DATE OF DEATH<br>MONTH 10 DAY 2 YEAR 90  |  | 3. TIME OF DEATH<br>3:29 A M  |  |
| 4. SOCIAL SECURITY NUMBER<br>215 40 7476  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>45 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>10/5/44  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Maryland General Hospital   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br>Md.   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>2000 N. Broadway  |  |  |  | 10f. ZIP CODE<br>21213  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Landscaping                     |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Gardening   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Robert Lee Johnson   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Hilda Mason  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Regina Handy   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1011 W. Lexington St. Balto., Md. 21223  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Western Star   |  | 20c. LOCATION — City or Town, State<br>Balto., Md.  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James A. Morton</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>James A. Morton & Sons<br>1701 Laurens St. Balto., Md. 21217  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Intra-cerebral Hemorrhage<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Hypertensive Cardiovascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Cirrhosis of the Liver; Renal Cell Carcinoma  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO            |  |
|   |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
|   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Frank J. Peretti</i>  |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>10/2/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Frank J. Peretti, M.D. 111 Penn St. Baltimore, Md. 21201   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 19146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the attending physician within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 90 26926   |
|--|--|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HARRY ZEE HOFFMAN</b>   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>27</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>2:30 PM</b>  |
| 4. SOCIAL SECURITY NUMBER<br><b>217-05-3638</b>  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>12/05/08</b> | 8. BIRTHPLACE (State or Foreign Country)<br><b>MD - USA</b>   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>LEVINDALE</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore MD</b>   |  | 9c. COUNTY OF DEATH   |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |   |
| 10e. STREET AND NUMBER<br><b>3910 Charles Lane</b>   |  | 10f. ZIP CODE<br><b>21215</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>WHITE</b>   |  |  |  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>3+</b> College (14 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>SELF EMPLOYED ARTIST</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>ART</b>  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>JOSEPH HOFFMAN</b>   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>JENNIE SAMUELSON</b>   |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MRS. JANE HOFFMAN</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3910 CLARKS LA. BALTIMORE, MD 21215</b>  |  |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BETH JACOB</b>  |  | 20c. LOCATION — City or Town, State<br><b>FINKSBURG, MD</b>   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</b>   |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>METASTATIC CANCER OF LARYNX &amp; EPIGLOTTIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |
|  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   | 28b. TIME OF INJURY<br><b>M</b>                        | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |
|  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  | 29c. LICENSE NUMBER<br><b>DI7037</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/27/90</b>   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ESTRELLITA O. Kim, M.D. - LEVINSON HEBREW GERIATRIC CENTER &amp; HOSPITAL</b>  |  |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed with 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other significant event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26927

|   |  |  |  |   |  |  |                                   |   |  |   |  |   |  |  |  |
|---|--|--|--|---|--|--|-----------------------------------|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>DAISY P EARLE HAWKINS   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>SEPT. 28, 1990  |  | 3. TIME OF DEATH<br>1:00PM M   |                                   |   |  |   |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>218-20-1599  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>88 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>1/8/02                                     |                                   | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Randolph Hills Nursing Home   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Wheaton  |  |  | 9c. COUNTY OF DEATH<br>Montgomery |   |  |   |  |   |  |  |  |
| 10a. STATE<br>Maryland  |  |  |  | 10b. COUNTY<br>Montgomery   |  | 10c. CITY, TOWN OR LOCATION<br>Damascus  |                                   | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |   |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>25909 Reva Drive  |  |  |  | 10f. ZIP CODE<br>20872  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |                                   |   |  |   |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |                                   |   |  |   |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (1-4 or 5+) 0  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Cafeteria Worker   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Army Map Service                                   |                                   |   |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>George M. Andrews  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Annie Emma Hawkins   |  |  |                                   |   |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>William W. Hawkins, Jr.   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>25909 Reva Dr, Damascus 20872  |  |  |                                   |   |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Tabor  |  | 20c. LOCATION — City or Town, State<br>Etchison, Md.  |  |  |                                   |   |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Muriel H. Barber</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Muriel H. Barber Funeral Home<br>P. O. Box 5038, laytonsville Md 20882  |  |  |                                   |   |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>cancer of the pancreas</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |  |                                   | Approximate Interval Between Onset and Death<br><i>2 months</i>   |  |   |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |                                   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |                                   |   |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |                                   |   |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |                                   |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>   |  | 29c. LICENSE NUMBER<br>D34032                   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/28/90 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>JEANNE P. ASNER 3720 FARRAGUT AVE KENSINGTON MD 20895  |  |  |  |   |  |  |                                   |   |  | 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i> |  |  |  |



ITEMS:17,18 per FH  
G-668 10-10-90 cm

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26928

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Mary Cecilia Hochrein</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 30 90</b>   |  | 3. TIME OF DEATH<br><b>M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-05-5540</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>96</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9-10 1894</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1635 Aberdeen Rd</b>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Towson</b>   |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  |   |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Towson</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 10e. STREET AND NUMBER<br><b>1635 Aberdeen Rd.</b>   |  |  |  |
| 10f. ZIP CODE<br><b>21204</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>12 yrs</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Bookkeeper</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Continental Can</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James Robert Allen JOHN HOCHREIN</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Marie E. Becker LUCY HEIL</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Miriam Fleagle</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1635 Aberdeen Rd. Towson, Md. 21204</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holy Redeemer 10-3-90</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b>   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Earl L. Papp</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, Md. 21204</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b><br>a. <b>Septicemia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>Decubitus ulcer of sacrum</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>7 days</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Earl L. Papp MD</i>  |  |   |  | 29c. LICENSE NUMBER<br><b>D 9386</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>Oct 1 1990</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Samuel O'Mansky 8405 A Loch Raven Blvd.</b>  |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26929

|   |  |  |  |   |  |  |   |  |  |
|---|--|--|--|---|--|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Dorothy Jones Dorothy Virginia Jones</b>   |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>2</b> YEAR <b>90</b>            |   | 3. TIME OF DEATH<br><b>8:26 A</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>2-191608664</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>3/3/27</b>                       |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Md. USA</b>                                     |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Harbor Hospital Center</b>   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>               |   | 9c. COUNTY OF DEATH<br><b>N/A</b>  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |   |  |  |
| 10a. STATE<br><b>Md.</b>  |  | 10b. COUNTY<br><b>Anne Arundel Co.</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Glen Burnie,</b>  |  |  |   | 10d. INSIDE CITY LIMITS<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>7845 Americana Circle, Apt. T-3</b>  |  |  |  | 10f. ZIP CODE<br><b>21061</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                |   |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b></b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Homemaker</b>  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Domestic Caretaker</b>             |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph Fabian</b>   |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Emma Horlacher</b> |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. William J. Jones</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2856 Country Lane, Ellicott City, Maryland 21043</b>  |  |  |   |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>  |  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Maryland</b>       |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Kevin E. Ecker</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>McCully Funeral Home of Brooklyn 21225<br/>237 East Patapsco Ave., Baltimore, Md.</b>  |  |  |   |  |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Respiratory Failure</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><div style="display: flex; justify-content: space-between;"> <div> <b>Extensive Metastatic Disease</b><br/> <b>Carcinoma of uterus = metastases</b> </div> <div>           Approximate Interval Between Onset and Death<br/> <b>1 Day</b><br/> <b>sev. Months</b><br/> <b>2 years</b> </div> </div> |  |  |  |   |  |  |   |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Renal Failure</b><br><b>Dehydration</b><br><b>Acute Gastrointestinal Bleeding</b>  |  |  |  |   |  |  |   |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |   |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>  |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO    |  |
|   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |   |  |  |
|   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |  |  |
|   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |   |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Colvin C. Carter MD</b>   |  |  |  |   |  | 29c. LICENSE NUMBER<br><b>D01459</b>                                       |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>10/2/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Colvin C. Carter 4700 Pennington Ave Balto, Md. 21226</b>   |  |  |  |   |  |  |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 3 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |  |   |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

90 26930

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROBERT W. JOH</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>1</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>3:40 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>219-26-1247</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>54</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year) <b>9 7 36</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Baltimore</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>St. Agnes Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  |
| 9c. COUNTY OF DEATH  |  |  |  | 10. RESIDENCE OF DECEDENT   |  |   |  |
| 10a. STATE<br><b>Md</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Linthicum</b>   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><b>305 John Avenue</b>   |  |  |  | 10f. ZIP CODE<br><b>21090</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                          |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Mechanic</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Nor Auto Repair</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Fred C. Joh, Sr.</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Eva P. Schmidt</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Lisa Kennedy</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>305 John Avenue, Linthicum, Md. 21090</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Loudon Park</b>   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Raymond Peterson</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Hubbard Funeral Home Inc.<br/>4107 Wilkens Avenue, Baltimore, Md 21229</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Arteriosclerotic Cardiovascular Disease</b>  |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br><b>INSPECTION</b>   |  |  |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>XXXX Natural 6 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Ann M. Dixon</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>10-1-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Ann M. Dixon, M.D., Deputy Chief 111 Penn Street, Baltimore, MD 21201 vl</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26931

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br>BERNARD ALBERT KUHN   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>SEPT. 30, 1990   |  | 3. TIME OF DEATH<br>M  |  |
| 4. SOCIAL SECURITY NUMBER<br>220-20-1100  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                     |  | 6. AGE (In yrs. last birthday)<br>61 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>4-10-1929   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>FRANCIS SCOTT KEY MEDICAL CENTER |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY  |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br>MARYLAND  |  |  |  | 10b. COUNTY<br>BALTIMORE   |  | 10c. CITY, TOWN OR LOCATION<br>DUNDALK   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br>21 PATAPSCO AVENUE   |  | 10f. ZIP CODE<br>21222   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE   |  | 15. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12TH GRADE<br>College (1-4 or 5+) N/A             |  |
| 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>COURT COMMISSIONER  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>DISTRICT COURT   |  | 17. FATHER'S NAME (First, Middle, Last)<br>FREDERICK C. KUHN   |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>SOPHIA TRAGER  |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br>EDITH MAE KUHN   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>21 PATAPSCO AVENUE BALTIMORE, MARYLAND 21222    |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>OAK LAWN CEMETERY OCT. 3, 1990   |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MARYLAND   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Samuel T. Mulheisen</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>DUDA-RUCK FUNERAL HOME OF DUNDALK, INC.<br>7922 WISE AVENUE DUNDALK, MD 21222  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <i>Cardiac arrest</i><br>Due TO (OR AS A CONSEQUENCE OF):<br>b. <i>Coronary artery disease</i><br>Due TO (OR AS A CONSEQUENCE OF):<br>c. <i>Myocardial infarction</i><br>Due TO (OR AS A CONSEQUENCE OF):<br>d.<br>Approximate Interval Between Onset and Death<br><i>minutes</i><br><i>20+ yrs</i><br><i>20 yrs</i> |  |  |  | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Louis J. Olsen MD</i>   |  |  |  | 29c. LICENSE NUMBER<br>D18648  |  | 29d. DATE SIGNED (Month, Day, Year)<br>10/1/90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>LOUIS J. OLSEN, 1012 ULT N. PT. RD. - BALTO MD 21224   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Judith Davidson-Randall</i>  |  |  |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be completed with 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26932

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|  |  |   |                          |  |   |   |   |   |  |  |  |
|--|--|---|--------------------------|--|---|---|---|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>NITA B. KRAUS  |  |   |                          | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 1, 1990  |   | 3. TIME OF DEATH<br>7:45 P, M                           |   |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>214-01-9827   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                          | 6. AGE (In yrs. last birthday)<br>88 YRS.  |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Aug. 13, 1902 |   | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Maryland Masonic Homes   |  |   |                          | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Cockeysville  |   |   | 9c. COUNTY OF DEATH<br>Baltimore                                    |   |  |  |  |
| 10a. STATE<br>Maryland   |  |   | 10b. COUNTY<br>Baltimore |  | 10c. CITY, TOWN OR LOCATION<br>Cockeysville           |   |   | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br>300 International Circle   |  |   |                          | 10f. ZIP CODE<br>21030   |   |   | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                                |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |                          | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |   |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 Years<br>College (1-4 or 5+) College (1-4 or 5+)  |  |   |                          | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker   |   |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Home                              |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Thomas H. Brinsfield  |  |   |                          | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Adelia Jones  |   |   |   |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Maryland Masonic Homes   |  |   |                          | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>300 International Circle, Cockeysville, Md. 21030   |   |   |   |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Olivet Cemetery   |                          |  | 20c. LOCATION — City or Town, State<br>Baltimore, Md. |   |   |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>James F. Burnside, Jr.  |  |   |                          | 22. NAME AND ADDRESS OF FACILITY<br>Mitchell-Wiedefeld Home, Inc.<br>6500 York Rd. Baltimore, Md. 21212  |   |   |   |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |                          |  |   |   |   | Approximate Interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                          |  |   |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |                          | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |   |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |   |                          | 28a. DATE OF INJURY (Month, Day, Year)   |   | 28b. TIME OF INJURY<br>M                                |   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |                          | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |   |   |   |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |                          | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Paul M. Rivas, M.D.   |   |   |   | 29c. LICENSE NUMBER<br>D25488   |  | 29d. DATE SIGNED (Month, Day, Year)<br>Oct. 2, 1990  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Paul M. Rivas, M.D. 300 International Circle, Cockeysville, Md. 21030   |  |   |                          |  |   |   |   |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990   |  |   |                          | 32. REGISTRAR'S SIGNATURE<br>John S. ...   |   |   |   |   |  |  |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed and filed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26933

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>EVELYN E. KLABURNER</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>09 - 28 - 90</b>   |  | 3. TIME OF DEATH<br><b>10:10 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-22-9832</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>80</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>08-19-10</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TOWSON</b>  |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>  |  |
| 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>HARFORD</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BEL AIR</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br><b>126 NORTH HICKORY AVE.</b>  |  |  |  | 10f. ZIP CODE<br><b>21014</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 yrs.</b><br>College (1-4 or 5+) <b></b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>House wife</b>           |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>home</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Richard Swindell</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mary Vitak</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mr. Richard J. Sherrill</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1901 Moore Rd. Forest Hill, Md. 21050</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metro Crematory/London Pk. Cem.</b>                             |  | 20c. LOCATION — City or Town, State<br><b>Balto. Md.</b>  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>E. F. Lassahn</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>E.F. Lassahn Funeral home<br/>11750 Belair Rd. Kingsville, Md. 21087</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → MYOCARDIAL INFARCTION</b><br><b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>C.O.P.D.</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><b>CORONARY ARTERY DISEASE</b><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>1 wk</b><br><b>YEARS</b><br><b>YEARS</b>  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28e. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
|  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Donald L. Somerville, MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D-12991</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>10/1/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DONALD SOMMERVILLE, MD. G.B.M.C. 6701 N. CHARLES ST. TOWSON, MD. 21204</b>   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>   |  |  |  |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed with 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26934

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

|  |  |  |  |   |  |  |  |   |  |   |  |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Virginia M. Lee  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>10/01-90  |  | 3. TIME OF DEATH<br>M  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>216 14 7652   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>YRS. 73   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>3/5/17  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Md.   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>3 Solar Circle   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Balto.   |  |  |  | 9c. COUNTY OF DEATH   |  |   |  |
| 10a. STATE<br>Md.  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>BALTO.   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |
| 10e. STREET AND NUMBER<br>3 Solar Circle   |  |  |  | 10f. ZIP CODE<br>21234  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black                                 |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Factory   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Eddie Lee   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Luvenia Douglas  |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Dorothy Hutchinson   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3 Solar Circle   |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Baltimore Cem.   |  |   |  | 20c. LOCATION — City or Town, State<br>Balto., Md.                                   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>James A. Morton   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>James A. Morton & Sons<br>1701 Laurens St. Balto., Md. 21217  |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Carcinoma of the lung<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  | Approximate interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO      |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>James A. Morton   |  |  |  |   |  | 29c. LICENSE NUMBER<br>D01373  |  | 29d. DATE SIGNED (Month, Day, Year)<br>10-2-90  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Rendell  |  |  |  |   |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for use as the burial-transit permit, or removal. IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26935

|  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>BABY TASHIERA MILLIGAN</b>  |  |  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>30</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>1500</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>n/a</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>YRS. <b>6</b> MONTHS <b>19</b> DAYS <b>19</b> HOURS <b>3</b> MIN.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>3/12/90</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Balt MD</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Sinai Hospital</b>  |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |  | 9c. COUNTY OF DEATH<br><b>Baltimore</b>  |  |
| 10a. STATE<br><b>MD</b>  |  |  |  |  |  | 10b. COUNTY<br><b>Baltimore</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  |  |  | 10e. STREET AND NUMBER<br><b>3304 Roslyn</b>   |  | 10f. ZIP CODE<br><b>21216</b>  |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>US</b>   |  |  |  |  |  | 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES       |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Derrick milligan</b>   |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Judith Allen</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>JUDITH ALLEN</b>  |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2304 ROSLYN AVENUE: BALTIMORE, MD 21216</b>                                |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> 2 Cremation <input type="checkbox"/> 3 Removal from State<br><input type="checkbox"/> 4 Donation <input type="checkbox"/> 5 Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>WESTERN STAR CEMETERY</b>   |  |  |  | 20c. LOCATION — City or Town, State<br><b>CATONSVILLE, MD.</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>LEROY O. DYETT &amp; SON FUNERAL HOME<br/>4600 LIBERTY HEIGHTS AVENUE</b>   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary decompensation</b><br><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. <b>chronic BPD</b><br>c. <b>heart failure</b><br>d. |  |  |  |  |  | Approximate Interval Between Onset and Death   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> 2 ER/Outpatient <input type="checkbox"/> 3 DOA<br>OTHER: <input type="checkbox"/> 4 Nursing Home <input type="checkbox"/> 5 Residence <input type="checkbox"/> 6 Other (Specify) |  |  |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> 1 Natural <input type="checkbox"/> 5 Pending Investigation<br><input type="checkbox"/> 2 Accident <input type="checkbox"/> 6 Could not be determined<br><input type="checkbox"/> 3 Suicide <input type="checkbox"/> 8 Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> 1 YES <input checked="" type="checkbox"/> 2 NO   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  | 29c. LICENSE NUMBER<br><b>AJ4147357H8912</b>   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>9/30/90</b>  |  |  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print)<br><b>Sinai Hospital Baltimore MD</b>  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>  |  |  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |   | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |                                |  |  | REG. NO. 90 26936   |  |   |  |                                   |  |
|---|--|--|---|---|--------------------------------|--|--|---|--|---|--|-----------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>JOHN J MCCORMICK  |  |  |   | 2. DATE OF DEATH<br>MONTH 9 DAY 29 YEAR 1990  |                                | 3. TIME OF DEATH<br>10:30AM M                                    |  |   |  |   |  |                                   |  |
| 4. SOCIAL SECURITY NUMBER<br>212-01-7111  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>97 YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  | IF UNDER 24 HRS.<br>HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year)<br>4-17-1893                 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>423 E. Lake Ave.  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |                                | 9c. COUNTY OF DEATH<br>N/A                                       |  |   |  |   |  |                                   |  |
| 10a. STATE<br>Maryland  |  |  |   | 10b. COUNTY<br>N/A  |                                | 10c. CITY, TOWN OR LOCATION<br>Baltimore                         |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |   |  |                                   |  |
| 10e. STREET AND NUMBER<br>423 E. Lake Ave.  |  |  |   | 10f. ZIP CODE<br>21212  |                                | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                          |  |   |  |   |  |                                   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW I  |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |                                | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE |  |   |  |   |  |                                   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Artist  |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Newspaper   |                                |  |  |   |  |   |  |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Andrew McCormick   |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Elizabeth Lourie   |                                |  |  |   |  |   |  |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Andrew McCormick  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4314 Farmfield Road Baldwin Maryland 21013   |                                |  |  |   |  |   |  |                                   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>St. John's Cemetery  |   | 20c. LOCATION — City or Town, State<br>Hydes Maryland   |                                |  |  |   |  |   |  |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>George J. Ferrarse   |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Mitchell-Wiedefeld Home 6500 York Rd. 21212   |                                |  |  |   |  |   |  |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Carcinomatous</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b.<br>c.<br>d.<br>Approximate Interval Between Onset and Death<br>5 MONTHS |  |  |   |   |                                |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO      |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>  |  |  |   |   |                                |  |  |   |  |   |  |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |                                | 28a. DATE OF INJURY (Month, Day, Year)                           |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Walter R. Welzant MD  |   | 29c. LICENSE NUMBER   |                                | 29d. DATE SIGNED (Month, Day, Year)<br>Oct 1, 1990               |  |   |  |   |  |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Walter R. Welzant, M. D. 6100 York Rd. Baltimore, MD 21212   |  |  |   |   |                                |  |  |   |  |   |  |                                   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson   |   |   |                                |  |  |   |  |   |  |                                   |  |

11-11-76

11-11-76

11-11-76

11-11-76

11-11-76

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 90 26937  |   |
|--|--|--|--|---|---|
| 1 - FOR STATE REGISTRAR  |  |  |  | REG. NO.  |   |
| CERTIFICATE OF DEATH   |  |  |  |   |   |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ida Mondell</b>   |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>Sept 28, 1990</b>   |   | 3. TIME OF DEATH<br><b>12:30 P M</b>  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-07-6840</b>  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>77</b> YRS.   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>JAN 7, 1913</b>  | 8. BIRTHPLACE (State or Foreign Country)<br><b>MARYLAND</b>   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>5 Deauville Ct, Apt 2</b>   |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>  |   | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |
| RESIDENCE OF DECEDENT  |  |  |  |   |   |
| 10a. STATE<br><b>MD</b>  | 10b. COUNTY<br><b>Baltimore</b>  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |   |
| 10e. STREET AND NUMBER<br><b>5 Deauville Ct Apt 2</b>  |  | 10f. ZIP CODE<br><b>21208</b>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |   |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>   |  |   |   |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>SALESLADY</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>RETAIL</b>  |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>BENJAMIN SANDLER</b>   |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>FANNIE RESNICK</b>   |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MR. ALLEN MONDELL</b>   |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5215 HOMER DALLAS, TEXAS 75206</b> |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Moses Montefiore</b>  |  | 20c. LOCATION City or Town, State<br><b>Balto. MD</b>   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Ellen Sue Levinson</b>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Sol LEVINSON &amp; BROS INC 21215<br/>6010 Reisterstown Rd Balto. MD</b>  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Lung Cancer</b><br>Approximate Interval Between Onset and Death <b>one year</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |
|  |  |  |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY M   |   |
|  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |   |
|  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Marshall A. June</b>   |  |  | 29c. LICENSE NUMBER<br><b>D17873</b>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/28/90</b>   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>4000 Old Court Rd Balto, MD 21208</b>  |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>Juan Davidson-Randall</b>  |  |   |   |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26938

|  |  |  |  |   |  |  |   |  |  |                                      |  |   |  |
|--|--|--|--|---|--|--|---|--|--|--------------------------------------|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Jeffrey Curtis Maier</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>29</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>908 P. M.</b>   |   |  |  |                                      |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-44-5029</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>44</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>07 13 46</b>                        |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Wash., D.C.</b> |  |                                      |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Howard County General Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Columbia</b>  |  |  | 9c. COUNTY OF DEATH<br><b>Howard</b>  |  |  |                                      |  |   |  |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY<br><b>Howard</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Elkridge</b>  |  |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |  |                                      |  |   |  |
| 10e. STREET AND NUMBER<br><b>6162 Lawyers Hill Rd.</b>   |  |  |  | 10f. ZIP CODE<br><b>21227</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                      |   |  |  |                                      |  |   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>                               |  |  |                                      |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>+3</b>   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Designer</b>   |  |   | 15b. KIND OF BUSINESS/INDUSTRY<br><b>Architectural</b>       |  |   |  |  |                                      |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph G. Maier</b>  |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Ruth C. Curtis</b>  |  |  |   |  |  |                                      |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ruth C. Heley</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3333 University Blvd., Kensington, Md. 20895</b>  |  |  |   |  |  |                                      |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Loudon Park Crematory</b>   |  |   | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b> |  |   |  |  |                                      |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Darryl L. Kaufman</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Gary L. Kaufman Funeral Homes<br/>5695 Main St., Elkridge, Md. 21227</b>   |  |  |   |  |  |                                      |  |   |  |
| 23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. CARDIAC ARREST</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>b. CARDIOMYOPATHY</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>c. HIV INFECTION - S&amp;P STAGE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>d.</b> |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |  |  |                                      |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DISSEMINATED M.A.I.</b>   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |                                      |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |  |                                      |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED                              |  |                                      |  |   |  |
| 29a. CERTIFIER<br>(Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>H.A. Oken</b>  |  |   |  |  |   |  |  | 29c. LICENSE NUMBER<br><b>3D1172</b> |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/29/90</b> |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>H.A. Oken MD 3460 ELLICOTT CENTER DR 103 E.C. MD 21043</b>   |  |  |  |   |  |  |   |  |  |                                      |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>9/28/90</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>J. Davidson-Randall</b>   |  |  |   |  |  |                                      |  |   |  |



TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 90 26939   |  |
|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>ELMER J. ODENSOS   |  |  |  | 2. DATE OF DEATH<br>MONTH 10 DAY 1 YEAR 90  |  |
| 4. SOCIAL SECURITY NUMBER<br>213-01-188  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (in yrs. last birthday)<br>83 YRS.   |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year) 7-1-07  |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  | 3. TIME OF DEATH<br>11:50 P.M.  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>MERCY Med. CENTR   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTO. MD.   |  |
| 9c. COUNTY OF DEATH  |  |  |  |   |  |
| 10a. STATE<br>Md   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |   |  |
| 10e. STREET AND NUMBER<br>1214 SARGEANT STREET   |  | 10f. ZIP CODE<br>21223   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE  |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) UNKNOWN<br>College (1-4 or 5+) College   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>CHAUFFEUR   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>E. J. EDLEN   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>GEORGE ODENSOS  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>JULIA E. THOMPSON   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>THELMA S. ODENSOS  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1214 SARGEANT STREET, BALTIMORE, MD. 21223  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>CROWNSVILLE VETERANS CEMETERY  |  | 20c. LOCATION — City or Town, State<br>CROWNSVILLE, MD  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  | 22. NAME AND ADDRESS OF FACILITY<br>HUBBARD FUNERAL HOME INC.<br>4107 WILKENS AVE., BALTIMORE, MD 21229  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiovascular collapse   |  |  |  |   |  |
| b. Myocardial infarction   |  |  |  |   |  |
| Sequitely flit conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Pneumonitis, unknown etiology  |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br>10/2/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Harry Greenup, MD 301 St. Paul Plne Balt. MD 21201  |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |

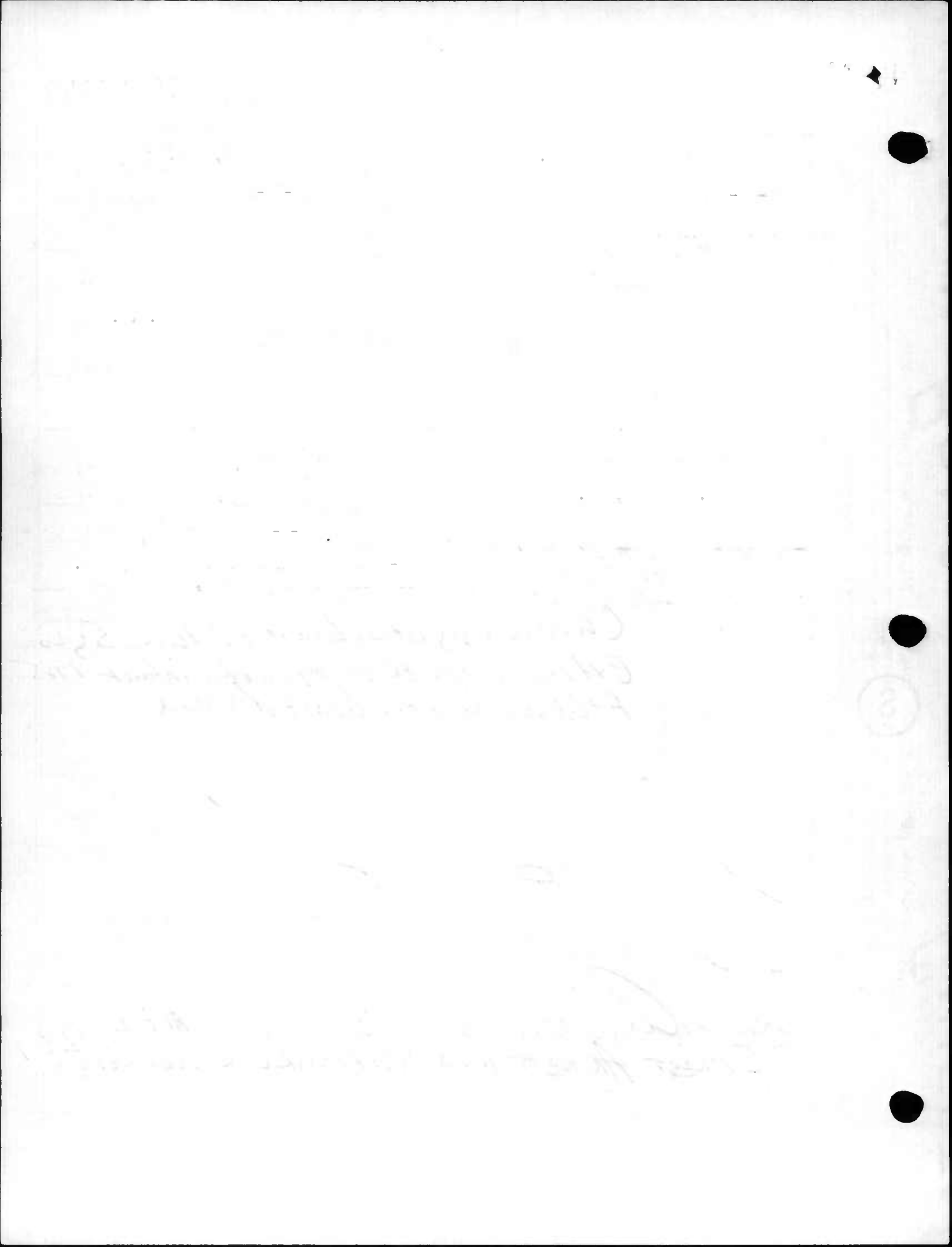


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|---|--|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>HELEN ESTELLE PALASIK  |  |  |  |   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>OCTOBER 7, 1990   |  |  |  | 3. TIME OF DEATH<br>M   |  |  |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>213-20-1017   |  |  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>64 YRS. |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>6-11-1926   |  | 8. BIRTHPLACE (State or Foreign Country)<br>MARYLAND |  |   |  |  |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>8015 STRATMAN ROAD   |  |  |  |   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>DUNDALK  |  |  |  | 9c. COUNTY OF DEATH<br>BALTIMORE  |  |  |  |   |  |  |  |
| 10a. STATE<br>MARYLAND   |  |  |  | 10b. COUNTY<br>BALTIMORE  |  |   |  | 10c. CITY, TOWN OR LOCATION<br>DUNDALK  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |  |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>8015 STRATMAN ROAD   |  |  |  |   |  |   |  | 10f. ZIP CODE<br>21222  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |  |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE  |  |  |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6TH GRADE<br>College (1-4 or 5+) N/A   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>HOME MAKER   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>HOME  |  |  |  |   |  |  |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>NICHOLAS GWIAZDOWSKI  |  |  |  |   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ALICE LEGGIN   |  |  |  |   |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>CHARLES F. PALASIK, JR.  |  |  |  |   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8015 STRATMAN ROAD BALTIMORE, MARYLAND 21222   |  |  |  |   |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>SACRED HEART OF MARY CEM. 10-5-90   |  |   |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MARYLAND  |  |  |  |   |  |  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Charles F. Palasik, Jr.   |  |  |  |   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>DUDA-RUCK FUNERAL HOME OF DUNDALK, INC.<br>7922 WISE AVENUE DUNDALK, MD 21222   |  |  |  |   |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Chronic congestive heart failure 5 yrs<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF): Extensive anterior myocardial infarct 1995<br>b. DUE TO (OR AS A CONSEQUENCE OF): Atherosclerotic heart disease<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   |  |   |  |  |  | Approximate interval Between Onset and Death  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M                  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED                    |  |   |  |  |  |   |  |  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  |   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |   |  |  |  | 29b. LICENSE NUMBER<br>819245   |  |  |  | 29c. DATE SIGNED (Month, Day, Year)<br>Oct 2, 1990  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>CRIST ALBERT M.D. 9101 Franklin Square, 21227   |  |  |  |   |  |   |  |   |  |  |  |   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990   |  |  |  |   |  |   |  |   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |  |  |   |  |  |  |



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26941

1 - FOR  
STATE  
REGISTRAR

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>STANLEY P. E. PRICE</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 21 90</b>  |  | 3. TIME OF DEATH<br><b>5:50 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>164-26-6085</b>   |  | 6. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>56</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Aug 28, 1938</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b>   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>19931 Toms Road</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Boonsboro</b>   |  | 9c. COUNTY OF DEATH<br><b>Washington</b>  |  |
| 10a. STATE<br><b>West Virginia</b>  |  | 10b. COUNTY<br><b>Jefferson</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Harpers Ferry</b>   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                               |  |
| 10e. STREET AND NUMBER<br><b>P.O. Box 930</b>   |  | 10f. ZIP CODE<br><b>25425</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Research Developer</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Gov't</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Terrell Price</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lillian Gloninger</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Marilyn M. Price</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 930 Harpers Ferry, West Virginia 25425</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Potomac Crematory</b>  |  | 20c. LOCATION — City or Town, State<br><b>Dale City, Virginia</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i> MD. 080   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Cunningham Funeral Home<br/>P.O. Box 65 Alex., Va. 22313</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Gunshot Wound of Chest</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>  |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |   |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Scene</b>  |  | 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>9-21-90</b>  |  | 28b. TIME OF INJURY<br><b>5:20 P M</b>  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Subject was shot</b>  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>farmhouse</b>  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>19931 Toms Road, Washington County, MD</b> |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Donald G. Wright</i>  |  |   |  | 29c. LICENSE NUMBER<br><b>OCME</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9-22-90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Donald G. Wright, M.D., Deputy Chief 111 Penn Street, Baltimore, MD 21201 vl</b>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. DECEDENT'S NAME (First, Middle, Last)   |  |  |                                | 2. DATE OF DEATH  |                                   | 3. TIME OF DEATH  |   |
|--|--|--|--------------------------------|---|-----------------------------------|---|---|
| CARL A. ROBINSON   |  |  |                                | 09-30-90  |                                   | M   |   |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX   | 6. AGE (In yrs. last birthday) | 7. DATE OF BIRTH  |                                   | 8. BIRTHPLACE (State or Foreign Country)                                |   |
| 405-16-4709  |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 68 YRS.                        | 06-02-22  |                                   | CANADA  |   |
| 9a. FACILITY NAME (If not institution, give street and number)   |  |  |                                | 9b. CITY, TOWN OR LOCATION OF DEATH   |                                   | 9c. COUNTY OF DEATH   |   |
| 6911 LACHLAN CIRCLE APT-E  |  |  |                                | BALTIMORE, MD   |                                   |   |   |
| 10a. STATE   |  | 10b. COUNTY  |                                | 10c. CITY, TOWN OR LOCATION   |                                   | 10d. INSIDE CITY LIMITS?  |   |
| MD   |  |  |                                | BALTIMORE, CITY   |                                   | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER   |  |  |                                | 10f. ZIP CODE   |                                   | 10g. CITIZEN OF WHAT COUNTRY?   |   |
| 6911 LACHLAN CIRCLE APT-E  |  |  |                                | 21239   |                                   | USA   |   |
| 11. MARITAL STATUS   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |                                | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) |                                   | 14. RACE — American Indian, Black, White, etc. Specify:                 |   |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |                                | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:                            |                                   | BLACK   |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)  |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. DO NOT use retired.)   |                                | 15b. KIND OF BUSINESS/INDUSTRY  |                                   |   |   |
| Elementary/Secondary (0-12)  |  | College (1-4 or 5+)  |                                | STATE OF MARYLAND   |                                   |   |   |
| 4yrs.  |  |  |                                |   |                                   |   |   |
| 17. FATHER'S NAME (First, Middle, Last)  |  |  |                                | 16. MOTHER'S NAME (First, Middle, Maiden Surname)   |                                   |   |   |
| HARRY ROBINSON   |  |  |                                | AUGUSTA CRIDER  |                                   |   |   |
| 19a. INFORMANT'S NAME (Type/Print)   |  |  |                                | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)               |                                   |   |   |
| DORIS ROBINSON   |  |  |                                | APT-E<br>6911 LACHLAN CIRCLE-BALTIMORE, MD. 21239   |                                   |   |   |
| 20a. METHOD OF DISPOSITION   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |                                | 20c. LOCATION — City or Town, State   |                                   |   |   |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | OAK GROVE CEMETERY   |                                | MCCRACHEN CO., KY.  |                                   |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |  |                                | 22. NAME AND ADDRESS OF FACILITY  |                                   |   |   |
| Blady Wanes  |  |  |                                | WM.C. MARCH F.H. 1101 E. NORTH AVE.   |                                   |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |                                |   |                                   |   | Approximate Interval Between Onset and Death                                |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |                                |   |                                   |   | 6 months  |
| a. neurogenic sarcoma<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |                                |   |                                   |   |   |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |                                |   |                                   |   |   |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |                                |   |                                   |   |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |  |                                |   |                                   |   |   |
| d. paraneoplastic pemphigus  |  |  |                                |   |                                   |   |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |                                |   |                                   |   |   |
| 24a. WAS AN AUTOPSY PERFORMED?   |  |  |                                |   |                                   |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |                                |   |                                   |   | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?   |  | 26. PLACE OF DEATH (Check only one)  |                                |   |                                   |   |   |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |   |                                   |   |   |
| 27. MANNER OF DEATH  |  | 28a. DATE OF INJURY (Month, Day, Year)   | 28b. TIME OF INJURY            | 28c. INJURY AT WORK?  | 28d. DESCRIBE HOW INJURY OCCURRED |   |   |
| 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide |  |  | M                              | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |                                   |   |   |
|  |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |                                | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                                |                                   |   |   |
|  |  |  |                                |   |                                   |   |   |
| 29a. CERTIFIER (Check only one)  |  |  |                                |   |                                   |   |   |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |                                |   |                                   |   |   |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |                                |   |                                   |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |  |                                | 29c. LICENSE NUMBER   |                                   | 29d. DATE SIGNED (Month, Day, Year)                                     |   |
| Alan Duncan MD   |  |  |                                | E9890   |                                   | 10/01/90  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |                                |   |                                   |   |   |
| Alan Duncan MD 600 N. Wolfe St. Baltimore MD   |  |  |                                |   |                                   |   |   |
| 31. DATE FILED (Month, Day, Year)  |  | 32. REGISTRAR'S SIGNATURE  |                                |   |                                   |   |   |
| 10 OCT 23 1990   |  | Jina Davidson-Randall  |                                |   |                                   |   |   |



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26943

|   |  |  |  |   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>EDWARD ALBERT RASSA JR  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9 23 90   |  | 3. TIME OF DEATH<br>3:30 P M                                     |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>213-40-0286  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>49 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>4-11-41                |  | 8. BIRTHPLACE (State or Foreign Country)<br>BALTIMORE   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>716 WALTERS MILL RD   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>FOREST HILL  |  |  |  | 9c. COUNTY OF DEATH<br>HARFORD MD   |  |  |  |
| 10a. STATE<br>MD  |  |  |  | 10b. COUNTY<br>HARFORD  |  | 10c. CITY, TOWN OR LOCATION<br>FOREST HILL                       |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br>716 WALTERS MILL RD   |  |  |  | 10f. ZIP CODE<br>21050  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA                             |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: WHITE |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>9th grade --   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>TRUCK DRIVER   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>TRANSPORT                      |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>EDWARD ALBERT RASSA JR   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>RUTH COX   |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>WENDY WACHTER   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>716 WALTERS MILL RD  |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Parkwood Cemetery   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Maryland       |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>M. Bladden Runk III  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Kurtz Funeral Home<br>Jarrettsville, Maryland 21084   |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GUN SHOT WOUND TO HEAD<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br>1 HR  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>NA  |  | 28b. TIME OF INJURY<br>NA M                                      |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO           |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>NA  |  |
|   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>NA  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>NA                        |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Gammert DME  |  |  |  |   |  | 29c. LICENSE NUMBER<br>D 21809                                   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9 23 90  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>1810 BELAIR RD #102 FALLSTON MD 21047 301-879-6564   |  |  |  |   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Siskin   |  |  |  |   |  |  |  |



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the cause of death be secured within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO.  |   |
|--|--|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>JOSEPH B SETH</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>29</b> YEAR <b>1990</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>212-10-0648</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11 09 1905</b>  |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>G.B.M.C., 6701 N. CHARLES STREET</b>  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>TOWSON</b>   |   | 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>               |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |   |
| 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  | 10e. STREET AND NUMBER<br><b>115 YORKLEIGH ROAD</b>  |   |   |
| 10f. ZIP CODE<br><b>21204</b>  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |   |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |   |
| 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |  |  | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>           |   |   |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Executive</b>   |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>C &amp; P Telephone Co.</b>   |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Dr Joseph B. Seth</b>  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Hannah H. Dodson</b>   |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Susan S. Griswold</b>  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>902 Sunset Dr. Greensboro, N. C. 27408</b> |   |   |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Olivet Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>St. Michaels, MD</b>  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Sherman Denny, Inc.</i>  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>MITCHELL-WIEDEFELD HOME, INC.<br/>6500 York Road Baltimore, Md. 21212</b>                               |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebral Anoxia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. <b>Abdominal Aortic aneurysm leak</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cardiovascular disease</b> |  |  |  |   | Approximate Interval Between Onset and Death          |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO        |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |   |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |   |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>A. Chakravarty</i>   |  |  | 29c. LICENSE NUMBER<br><b>D34723</b>   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/29/90</b> |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>DR. ASHISH K. CHAKRAVARTHY G.B.M.C. 6701 NORTH CHARLES STREET</b>  |  |  |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>9 OCT 03 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Pondore</i>  |  |   |   |



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

90005  
26945

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SAMUEL SHER (SAMUEL CARLISE SHER)</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>02</b> DAY <b>27</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>6:45 PM</b>  |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>2/25/09</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>NEW YORK</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>   |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>7121 PARK HEIGHTS AVE., APT. 609</b>  |  |  |  | 10f. ZIP CODE<br><b>21215</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>WWII</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4+</b> College (1-4 or 5+) <b>4+</b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>INVESTOR</b>                               |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>REAL ESTATE</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ELIAS SHER</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>LENA RABINOWITZ</b>   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MRS. LILLIE SHER</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7121 PARK HEIGHTS AVE., APT. 609 BALTO., MD 21215</b>                                       |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>HEBREW YOUNG MEN</b>  |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Isa Levinson</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SOL LEVINSON &amp; BROS., INC.<br/>6010 REISTERSTOWN RD. BALTO., MD 21215</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIOPULMONARY ARREST</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>METASTATIC MALIGNANT MELANOMA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>BLEEDING</b><br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>BLEEDING</b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Joni Urlanda - HOUSESTAFF SINAI HOSP</i>   |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/27/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>JONI URLANDA - SINAI HOSPITAL</b>  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Jane Davidson-Rondella</i>  |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic agent, the medical examiner must be notified at once.

000000 00



90 26946

**BALTIMORE, MARYLAND 21203-3146**

DIVISION OF VITAL RECORDS, P.O. BOX 18146,


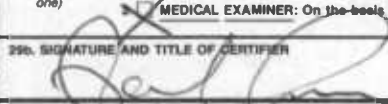
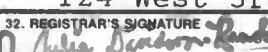
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be processed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, Bureau of Vital, Cremation, or Removal.

**IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Beatrice Jeanette Shoemaker</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 6 90</b>   |  | 3. TIME OF DEATH<br><b>0649A</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>235-72-1209</b>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br><b>50</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>11/28/39</b>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>WV</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Memorial Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Cumberland</b>  |  | 9c. COUNTY OF DEATH<br><b>Allegany</b>  |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |   |  |
| 10a. STATE<br><b>W. Va</b>  |  | 10b. COUNTY<br><b>Hardy</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>Moorefield</b>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>Rt 4 Box 31</b>  |  |  |  | 10f. ZIP CODE<br><b>26836</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>white</b>   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11</b><br>College (1-4 or 5+) <b></b>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>housekeeper</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Howard Sions</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Mae Weatherholtz</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Theresa Crider</b>   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Purgitsville, WV 26852</b>   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Olivet Cemetery</b>   |  | 20c. LOCATION — City or Town, State<br><b>Moorefield, WV 26836</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Elmore-Chambers Funeral Home<br/>Moorefield, WV 26836</b>   |  |   |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Multiple trauma with complications</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
|   |  |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Nonlethal<br>4 <input type="checkbox"/> Nonlethal  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>8/26/90</b>   |  | 28b. TIME OF INJURY<br><b>4:55 PM</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br><b>Jeep truck ran off road</b>   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>Road- Rt 220 N. Hardy County, near Moorefield W Va.</b>  |  |   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><br><b>Dpty Med. Ex</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D 09157</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/6/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Paul Snow, M.D. 124 West 3rd St Cumberland Md 21502</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 90 26947   |  |                                   |  |
|---|--|---|--|--|--|--|--|--|--|-----------------------------------|--|
| 1. DECEASED'S NAME (First, Middle, Last)  |  |   |  | 2. DATE OF DEATH   |  |  |  | 3. TIME OF DEATH   |  |                                   |  |
| DOUGLAS SHARRETT  |  |   |  | 10 01 90   |  |  |  | 4:10 A M   |  |                                   |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX  |  | 6. AGE (In yrs. last birthday)   |  | 7. DATE OF BIRTH                               |  | 8. BIRTHPLACE (State or Foreign Country)                     |  |                                   |  |
| 213 09 9111   |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F    |  | 80 YRS.  |  | 10/24/1909                                     |  | MARYLAND   |  |                                   |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |  |  | 9c. COUNTY OF DEATH  |  |                                   |  |
| GREATER BALTIMORE MEDICAL CENTER  |  |   |  | TOWSON   |  |  |  | BALTIMORE  |  |                                   |  |
| 10a. STATE  |  |   |  | 10b. COUNTY  |  |  |  | 10c. CITY, TOWN OR LOCATION                                  |  |                                   |  |
| MD  |  |   |  | BALTIMORE  |  |  |  | RUXTON   |  |                                   |  |
| 10d. INSIDE CITY LIMITS?  |  |   |  | 10e. ZIP CODE  |  |  |  | 10f. CITIZEN OF WHAT COUNTRY?                                |  |                                   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  | 21204  |  |  |  | USA  |  |                                   |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES?                             |  | 13. WAS DECEASED OF HISPANIC ORIGIN?   |  | 14. RACE — American Indian, Black, White, etc. |  |  |  |                                   |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married  |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | Specify: WHITE                                 |  |  |  |                                   |  |
| 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | IF YES, GIVE WAR OR DATES   |  | Specify: WW II   |  |  |  |  |  |                                   |  |
| 15. DECEASED'S EDUCATION  |  |   |  | 16a. DECEASED'S USUAL OCCUPATION   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY                               |  |                                   |  |
| (Specify only highest grade completed)  |  |   |  | (Give kind of work done during most of working life. Do NOT use retired.)  |  |  |  |  |  |                                   |  |
| Elementary/Secondary (0-12)   |  |   |  | College (1-4 or 5+)  |  |  |  | ATTORNEY   |  |                                   |  |
| 4+  |  |   |  |  |  |  |  | LAW  |  |                                   |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |  |  |  |  |                                   |  |
| RALPH SHARRETT  |  |   |  | MARGARET CAMBELL   |  |  |  |  |  |                                   |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |  |  |  |  |                                   |  |
| GERMAINE SHARRETT   |  |   |  | 2015 SKYLINE ROAD, RUXTON, MARYLAND 21204  |  |  |  |  |  |                                   |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE OF DISPOSITION   |  | 20c. LOCATION — City or Town, State  |  |  |  |  |  |                                   |  |
| 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State   |  | (Name of cemetery, crematory or other place)                            |  | GREEN MOUNT CEMETERY   |  | BALTIMORE, MARYLAND                            |  |  |  |                                   |  |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |  |  |  |  |                                   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |   |  | 22. NAME AND ADDRESS OF FACILITY   |  |  |  |  |  |                                   |  |
| <i>John L. Ebaugh</i>   |  |   |  | A. ALAN SEITZ, JR. FUNERAL HOME  |  |  |  |  |  |                                   |  |
|   |  |   |  | 3818 ROLAND AVENUE, BALTO., MD. 21211  |  |  |  |  |  |                                   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death                 |  |                                   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. COPD INSTAGE ENDSTAGE  |  |   |  |  |  |  |  | 10 yrs   |  |                                   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |   |  |  |  |  |  |  |  |                                   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |   |  |  |  |  |  |  |  |                                   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |  |  |  |  |                                   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):   |  |   |  |  |  |  |  |  |  |                                   |  |
| d. Acute bronchitis   |  |   |  |  |  |  |  | 2 wks  |  |                                   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  |  |  |                                   |  |
| CARDIAC ARRHYTHMIA  |  |   |  |  |  |  |  |  |  |                                   |  |
| 24a. WAS AN AUTOPSY PERFORMED?  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  |  |  |  |  |  |                                   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |  |  |                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  |   |  | 26. PLACE OF DEATH (Check only one)  |  |  |  |  |  |                                   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |                                   |  |
| 27. MANNER OF DEATH   |  |   |  | 28a. DATE OF INJURY  |  | 28b. TIME OF INJURY                            |  | 28c. INJURY AT WORK?   |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |   |  | 8 <input type="checkbox"/> Pending Investigation   |  | M  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |                                   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |                                   |  |
| 29a. CERTIFIER (Check only one)   |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER  |  | 29c. LICENSE NUMBER                            |  | 29d. DATE SIGNED (Month, Day, Year)                          |  |                                   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                        |  |   |  | William E. Randall Jr MD   |  | D15808   |  | 10-1-90  |  |                                   |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |  |  |                                   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |   |  |  |  |  |  |  |  |                                   |  |
| William E. Randall Jr #33, 1205 York Rd   |  |   |  |  |  |  |  |  |  | LUTHERVILLE MD 21093              |  |
| 31. DATE FILED (Month, Day, Year)   |  |   |  | REGISTRAR'S SIGNATURE  |  |  |  |  |  |                                   |  |
| OCT 03 1990   |  |   |  | John Davidson-Randall  |  |  |  |  |  |                                   |  |



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26948

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Harry Tillery JR.  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-28-90  |  | 3. TIME OF DEATH<br>4:25AM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>217-24-1087   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>59 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>7-27-31  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>1601 Abbottston Street   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City  |  | 9c. COUNTY OF DEATH<br>MD  |  |
| 10a. STATE<br>MD   |  |  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE, CITY   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br>1601 ABBOTTSTON STREET   |  | 10f. ZIP CODE<br>21218   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  | 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8TH<br>College (1-4 or 5+) College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>CONSTRUCTION  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>HARRY TILLERY   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>LETHA WALLER  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>LETHA TILLERY  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1601 ABBOTTSTON ST.-BALTIMORE, MD. 21218  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>WESTERN STAR CEMETERY  |  | 20c. LOCATION — City or Town, State<br>CATONSVILLE, MD.  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Janessa Coad  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>WM.C. MARCH F.H. 1101 E. NORTH AVE.  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic cardiovascular disease<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.  |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Chronic alcoholism   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Mario F. Golde, Jr.   |  |  |  | 29c. LICENSE NUMBER<br>OCME  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-28-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br>MARIO F. GOLDE, JR., MD 111 Penn Street, Baltimore, MD 21201   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P. O. BOX 15146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, 200 N. Enoch Avenue, Baltimore, Maryland 21201.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

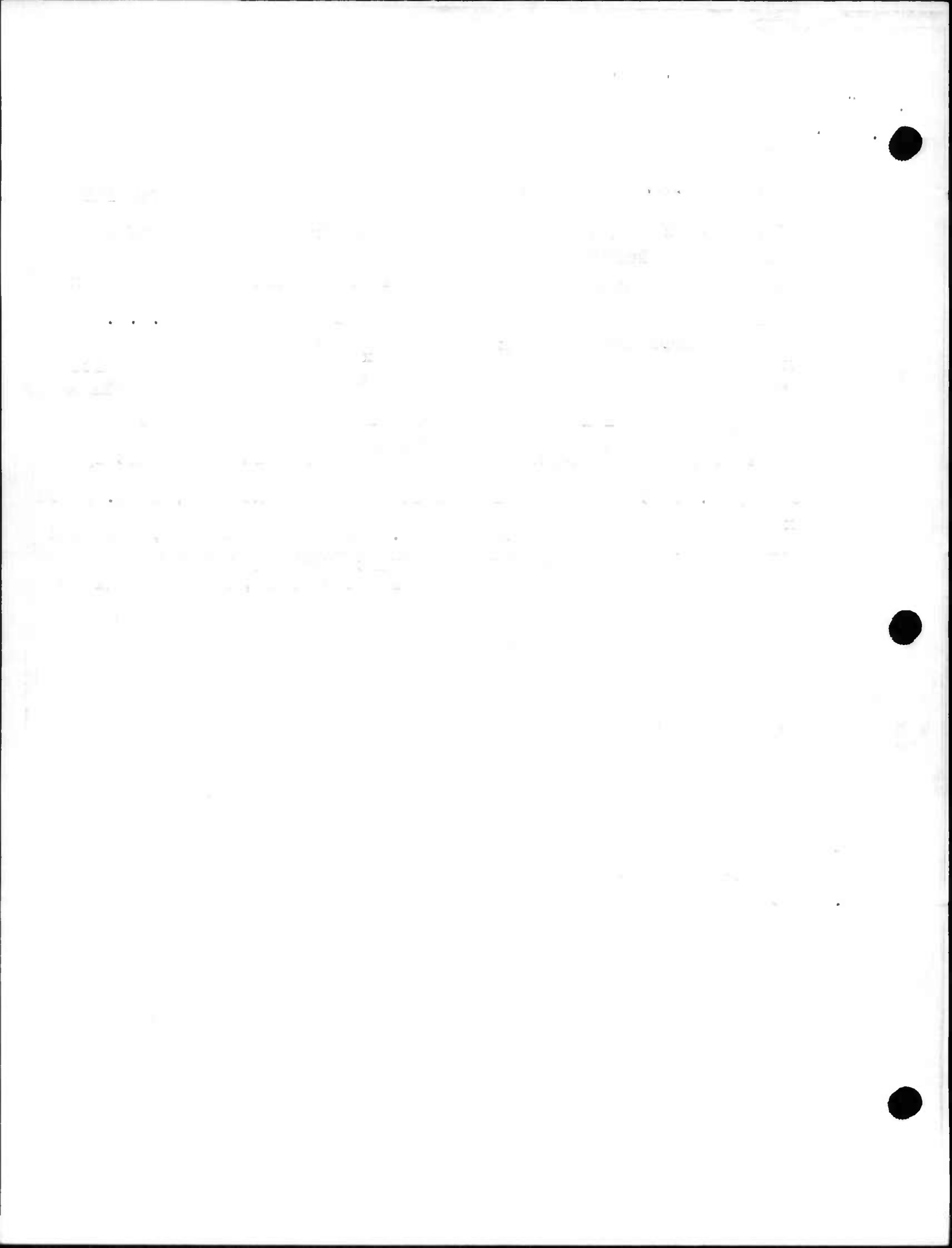


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| FOR STATE REGISTRAR   |  |   |                                | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |                     |  | 90 26949  |  |  |  |
|---|--|---|--------------------------------|--|--|---------------------|--|---|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)  |  |   |                                | 2. DATE OF DEATH   |  |                     |  | 3. TIME OF DEATH  |  |  |  |
| Marie Lou Testerman   |  |   |                                | 9 22 90  |  |                     |  | 10:05 AM  |  |  |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX  | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.    |  | 7. DATE OF BIRTH  |  | 8. BIRTHPLACE (State or Foreign Country) |  |
| 212-22-1138   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F    | 91 YRS.                        | MONTHS DAYS HOURS MIN.   |  |                     |  | 6-21-1899   |  | Virginia                                 |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |   |                                | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |                     |  | 9c. COUNTY OF DEATH   |  |  |  |
| Bel Forest Nursing Home   |  |   |                                | Bel Air  |  |                     |  | Harford   |  |  |  |
| RESIDENCE OF DECEASED   |  |   |                                | 10c. CITY, TOWN OR LOCATION  |  |                     |  | 10d. INSIDE CITY LIMITS?  |  |  |  |
| 10a. STATE  |  | 10b. COUNTY   |                                | Jarrettsville  |  |                     |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |  |  |
| Maryland  |  | Harford   |                                |  |  |                     |  |   |  |  |  |
| 10e. STREET AND NUMBER  |  |   |                                | 10f. ZIP CODE  |  |                     |  | 10g. CITIZEN OF WHAT COUNTRY?   |  |  |  |
| 1354 Knopp Road   |  |   |                                | 21084  |  |                     |  | U.S.A.  |  |  |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES?                             |                                | 13. WAS DECEASED OF HISPANIC ORIGIN?   |  |                     |  | 14. RACE — American Indian, Black, White, etc.                              |  |  |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                                | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |                     |  | Specify: White  |  |  |  |
| 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | IF YES, GIVE WAR OR DATES   |                                | Specify:   |  |                     |  |   |  |  |  |
| 15. DECEASED'S EDUCATION (Specify only highest grade completed)   |  |   |                                | 16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |                     |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| Elementary/Secondary (0-12) College (1-4 or 5+)   |  |   |                                | Housewife  |  |                     |  | Home  |  |  |  |
| 6   |  |   |                                |  |  |                     |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |   |                                | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |                     |  |   |  |  |  |
| Johnny Bauguess   |  |   |                                | Minnie Gaultney  |  |                     |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |   |                                | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |                     |  |   |  |  |  |
| Johnny R. Testerman   |  |   |                                | 100 Leslie Lane Hohenwald, Tenn. 38462   |  |                     |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION  |  |   |                                | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  |                     |  | 20c. LOCATION — City or Town, State   |  |  |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State   |  |   |                                | Bel Air Mem. Gardens   |  |                     |  | Bel Air, Maryland   |  |  |  |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |                                |  |  |                     |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |   |                                | 22. NAME AND ADDRESS OF FACILITY   |  |                     |  |   |  |  |  |
| M. Gladden  |  |   |                                | Kurtz Funeral Home Jarrettsville, Maryland 21084   |  |                     |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  |   |                                |  |  |                     |  | Approximate interval Between Onset and Death                                |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |   |                                |  |  |                     |  |   |  |  |  |
| a. DUE TO (OR AS A CONSEQUENCE OF):   |  |   |                                |  |  |                     |  |   |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):   |  |   |                                |  |  |                     |  |   |  |  |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):   |  |   |                                |  |  |                     |  |   |  |  |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):   |  |   |                                |  |  |                     |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |   |                                |  |  |                     |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                |  |  |                     |  | 24a. WAS AN AUTOPSY PERFORMED?  |  |  |  |
|   |  |   |                                |  |  |                     |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |  |  |
|   |  |   |                                |  |  |                     |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |  |  |  |
|   |  |   |                                |  |  |                     |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  |   |                                | 26. PLACE OF DEATH (Check only one)  |  |                     |  |   |  |  |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |                                | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                     |  |   |  |  |  |
| 27. MANNER OF DEATH   |  |   |                                | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY |  | 28c. INJURY AT WORK?  |  | 28d. DESCRIBE HOW INJURY OCCURRED        |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation  |  |   |                                |  |  | M                   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |  |  |
| 2 <input type="checkbox"/> Accident   |  |   |                                |  |  |                     |  |   |  |  |  |
| 3 <input type="checkbox"/> Suicide  |  |   |                                |  |  |                     |  |   |  |  |  |
| 4 <input type="checkbox"/> Homicide   |  |   |                                |  |  |                     |  |   |  |  |  |
| 8 <input type="checkbox"/> Could not be determined  |  |   |                                |  |  |                     |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)   |  |   |                                | 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |                     |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)      |  |
| 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                                   |  |   |                                | Andrew Nowakowski MD   |  |                     |  |   |  | 9/24/90                                  |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |                                |  |  |                     |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |   |                                |  |  |                     |  |   |  |  |  |
|   |  |   |                                |  |  |                     |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)   |  |   |                                | 32. REGISTRAR'S SIGNATURE  |  |                     |  |   |  |  |  |
| OCT 03 1990   |  |   |                                | John Testerman   |  |                     |  |   |  |  |  |





|   |  |  |  |   |  |  |  |   |   |   |  |   |  |
|---|--|--|--|---|--|--|--|---|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Thomas E. Thompson</b>   |  |  |  | 2. DATE OF DEATH<br><b>Sept. 28 1990</b>  |  | 3. TIME OF DEATH<br><b>11:45 a.m.</b>  |  |   |   |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-18-8373</b>   |  | 6. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 6. AGE (In yrs. last birthday)<br><b>75</b> YRS. | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.   |  | 7. DATE OF BIRTH<br><b>Oct. 1, 1914</b>   |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Montgomery General Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Olney</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |   |   |  |   |  |
| RESIDENCE OF DECEDENT   |  |  |  |   |  |  |  |   |   |   |  |   |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Howard</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Ellicott City</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO |   |   |  |   |  |
| 10e. STREET AND NUMBER<br><b>11340 Frederick Road</b>   |  |  |  | 10f. ZIP CODE<br><b>21043</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |   |  |   |  |
| 11. MARITAL STATUS<br><b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married<br><b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1941-1945</b> |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b> <b>5</b><br><b>College (1-4 or 6+)</b> <b>-</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Machinist</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Sheet Metal</b>  |   |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>James M. Thompson</b>   |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Margaret L. Gates</b>                      |  |   |   |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Kathleen K. Buck</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2943 Marriottsville Rd., Ellicott City, Md. 21043</b>   |  |  |  |   |   |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State<br><b>4</b> <input type="checkbox"/> Donation <b>6</b> <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Crestlawn Memorial Park</b>   |  |   |  | 20c. LOCATION — City or Town, State<br><b>Marriottsville, Md.</b>                                  |  |   |   |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Muriel H. Barber</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Muriel H. Barber Funeral Home</b><br><b>P O Box 5038, Laytonsville, Md. 20882</b>  |  |  |  |   |   |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death)</b> → <b>LUNG CANCER</b><br><b>Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b><br>a. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>b. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |  |  |   |  |  |  |   |   | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>EMPHYSEMA</b>  |  |  |  |   |  |  |  |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA<br>OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify) |  |  |  |   |   |   |  |   |  |
| 27. MANNER OF DEATH<br><b>1</b> <input type="checkbox"/> Natural <b>6</b> <input type="checkbox"/> Pending investigation<br><b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>6</b> <input type="checkbox"/> Could not be determined<br><b>4</b> <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |   |   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |   |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |   |   |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Robert Fields, M.D.</b>   |  |  |  |   |  | 29c. LICENSE NUMBER<br><b>D34740</b>   |  |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/28/90</b> |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>ROBERT FIELDS, MD</b> <b>18111 PRINCE PHILIP DR T-12, OLNEY, MD</b>   |  |  |  |   |  |  |  |   |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>   |  |  |  | REGISTRAR'S SIGNATURE<br><b>John Davidson-Randall</b>   |  |  |  |   |   |   |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26951

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEASED'S NAME (First, Middle, Last)<br>Isaac John Twining Jr.  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Sept. 28, 1990  |  | 3. TIME OF DEATH<br>1:17 P.M.   |   |
| 4. SOCIAL SECURITY NUMBER<br>217-36-4269  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>84 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>Feb. 15, 1906   |   |
| 8a. FACILITY NAME (If not institution, give street and number)<br>3982<br>Madonna Heritage Inc. Norrisville Rd.   |  |  |  | 8b. CITY, TOWN OR LOCATION OF DEATH<br>Jarrettsville, Md.   |  | 8c. COUNTY OF DEATH<br>Harford  |   |
| RESIDENCE OF DECEASED   |  |  |  |   |  |   |   |
| 10a. STATE<br>Md.   |  | 10b. COUNTY<br>Baltimore   |  | 10c. CITY, TOWN OR LOCATION<br>Glen Arm   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>11511 Harford Rd.   |  |  |  | 10f. ZIP CODE<br>21057  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR GATES   |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white                                    |   |
| 15. DECEASED'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8 yrs.   |  | 16a. DECEASED'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Farmer (retired)  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Self-employed   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Isaac John Twining Sr.   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Sara Burton  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Lillian E. Twining   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11511 Harford Rd. Glen Arm, Md. 21057  |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Parkwood Cemetery  |  | 20c. LOCATION — City or Town, State<br>Parkville, Md.   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>E. F. Lassahn  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>E. F. Lassahn Funeral Home<br>11750 Belair Rd. Kingsville, Md. 21087  |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Hypertensive Cardio-Vascular Disease</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>c. _____ DUE TO (OR AS A CONSEQUENCE OF):<br>d. _____ |  |  |  |   |  |   | Approximate interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Edema legs &amp; ulceration</u>  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>William A. Tyson M.D.  |  |  |  | 29c. LICENSE NUMBER<br>D11752   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-30-90  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Box 158<br>Dr. Wm. A. Tyson M.D. 11706 Silver Spruce Terrace, Kingsville, Md. 21087  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990  |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall   |  |   |  |   |   |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 90 26952

|   |  |                          |  |  |  |   |  |
|---|--|--------------------------|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DONALD TRAVERS</b>   |  |                          |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 - 27 - 90</b>   |  | 3. TIME OF DEATH<br><b>8:05P M</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>216-32-4772</b>   |  | 5. SEX<br><b>1 M 2 F</b> |  | 6. AGE (In yrs. last birthday)<br><b>54 YRS.</b>   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>9-16-36</b>                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>MD.</b>  |  |                          |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>University Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>                |  |
| 9c. COUNTY OF DEATH<br><b>MD.</b>   |  |                          |  | 10a. STATE<br><b>MD.</b>   |  | 10b. COUNTY<br><b>—</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Baltimore, Maryland</b>   |  |                          |  | 10d. INSIDE CITY LIMITS?<br><b>1 YES 2 NO</b>  |  | 10e. STREET AND NUMBER<br><b>501 DOLPHIN ST.</b>                            |  |
| 10f. ZIP CODE<br><b>21203</b>   |  |                          |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 11. MARITAL STATUS<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b> |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b><br>IF YES, GIVE WAR OR DATES  |  |                          |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 YES 2 NO</b> Specify:        |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>—</b> College (1-4 or 5+) <b>—</b>   |  |                          |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Laborer</b>                      |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>CONSTRUCTION</b>                       |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>CHARLES TRAVERS</b>   |  |                          |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Blanche Edmonds</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Mrs. Mildred Geter</b>   |  |                          |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5444 Belle Vista Ave. 21206</b>                  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>   |  |                          |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>BALTIMORE CEMETERY Baltimore, MD.</b>                                   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, MD.</b>                |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Randolph J. Collick</b>   |  |                          |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Collick F.H. 21203 2431 E. Oliver St. Balt., MD.</b>  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |                          |  |  |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardiopulmonary arrest.</b>   |  |                          |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |                          |  |  |  |   |  |
| b. <b>Chronic Myelogenous Leukemia</b>  |  |                          |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |                          |  |  |  |   |  |
| c. <b>Accelerated phase - Chronic Myelogenous Leukemia</b>  |  |                          |  |  |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |                          |  |  |  |   |  |
| d. <b>—</b>   |  |                          |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                          |  |  |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><b>1 YES 2 NO</b>   |  |                          |  |  |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><b>1 YES 2 NO</b>  |  |                          |  |  |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><b>1 YES 2 NO</b>   |  |                          |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |   |  |
| 27. MANNER OF DEATH<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>   |  |                          |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  |
| 28c. INJURY AT WORK?<br><b>1 YES 2 NO</b>   |  |                          |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |                          |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b><br><b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> |  |                          |  |  |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Rezaadeh M.D.</b>   |  |                          |  | 29c. LICENSE NUMBER<br><b>D37249</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/27/90</b>                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Hamied R. REZAADEH M.D. UNIV. OF MD. CANCER CENTER.</b>   |  |                          |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 03 1990</b>   |  |                          |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1944

The first of the year was a very dry one. The weather was very hot and the ground was very dry. The crops were very dry and the animals were very dry. The people were very dry and the children were very dry. The old people were very dry and the young people were very dry. The people were very dry and the children were very dry. The old people were very dry and the young people were very dry.

The second of the year was a very wet one. The weather was very cold and the ground was very wet. The crops were very wet and the animals were very wet. The people were very wet and the children were very wet. The old people were very wet and the young people were very wet. The people were very wet and the children were very wet. The old people were very wet and the young people were very wet.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26953

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br>SALLY WATERS   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>10 01 90  |  | 3. TIME OF DEATH<br>02:50 A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>217 20 8419   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>85 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>08-12-1905   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>GREATER BALTIMORE MEDICAL CENTER   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>TOWSON   |  | 9c. COUNTY OF DEATH<br>BALTIMORE  |  |
| 10a. STATE<br>MD   |  | 10b. COUNTY<br>BALTIMORE   |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE, CITY  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>1803 CHILTON STREET  |  |  |  | 10f. ZIP CODE<br>21218  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK                                    |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 5th<br>College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>DOMESTIC  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>JOSEPH TOWNES   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>JOSEPHINE BRANCH   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>MILDRED WILLIAMS   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1803 CHILTON ST.-BALTIMORE, MD. 21218  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>BALTIMORE NATIONAL CEM.  |  | 20c. LOCATION — City or Town, State<br>BALTIMORE, MD.   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Wm. C. March  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>WM.C. MARCH F.H. 1101 E. NORTH AVE.   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   | Approximate interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC COLON CANCER<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Julia Davidson-Randall MD   |  | 29c. LICENSE NUMBER<br>D 39258  |  | 29d. DATE SIGNED (Month, Day, Year)<br>10/1/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990   |  |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





90-5482  
ITEMS: 23, 27 per ME  
G-668 10-26-90 cm

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26954

|  |  |  |  |   |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Venobia Wilson   |  |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 30 YEAR 90  |  |  |  | 3. TIME OF DEATH<br>9:30 A M  |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>N/A   |  | 6. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>YRS. MONTHS DAYS 24   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>9-06-90                                    |  | 8. BIRTHPLACE (State or Foreign Country)<br>MD  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Union Memorial Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  |  |  | 9c. COUNTY OF DEATH   |  |  |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |  |  |   |  |  |  |
| 10a. STATE<br>MD   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE, CITY  |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br>614 GOLD STREET  |  |  |  | 10f. ZIP CODE<br>21217  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK                     |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) CHILD College (1-4 or 5+) CHILD  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>CHILD  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>CURTIS WILSON   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ANGELA RILEY   |  |  |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>CURTIS WILSON  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>614 GOLD STREET-BALTIMORE, MD. 21217   |  |  |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>GARRISON FOREST VET. CEM.  |  | 20c. LOCATION — City or Town, State<br>OWINGS MILLS, MD.  |  |  |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Vanessa Coad  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>WM.C. MARCH F.H. 1101 E. NORTH AVE.   |  |  |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUDDEN INFANT SYNDROME<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Ann M. Dixon, M.D.  |  |  |  |   |  | 29c. LICENSE NUMBER<br>OCME  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/30/90  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ann M. Dixon, M.D. 111 Penn St. Baltimore, Md. 21201  |  |  |  |   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Hendall   |  |  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 3146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

90 26955

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Walter Antonia Williams  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9 30 90   |  | 3. TIME OF DEATH<br>12:13 A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>216 86 6540   |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>23 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>4/23/67   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Union Memorial Hospital  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  | 9c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |
| 10a. STATE<br>Md.  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>4220 Ivanhoe Avenue  |  |  |  | 10f. ZIP CODE<br>21218  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black                                 |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>9   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Construction  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Building  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Walter Williams   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Vivian Williams  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Vivian Taylor  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4220 Ivanhoe Ave. Balto., Md. 21218  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Baltimore Cemetery   |  | 20c. LOCATION — City or Town, State<br>Balto., Md.  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>James A. Morton</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>James A. Morton & Sons<br>1701 Laurens St. Balto., Md. 21217  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gunshot Wound of Chest<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| c. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| d. DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |   |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 8 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 9 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 10 <input type="checkbox"/> Could not be determined<br>4 <input checked="" type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br>9/29/90   |  | 28b. TIME OF INJURY<br>P M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
|  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>subject was shot  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>5200 Blk. Alhambra Ave., Balto. City, Md.   |  |   |  |
| 29a. CERTIFIER<br>(Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29c. SIGNATURE AND TITLE OF CERTIFIER<br><i>Sharon F. Galle</i><br>OCME  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/30/90  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Mario F. Golle, Jr., M.D. 111 Penn St. Baltimore, Md. 21201   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990   |  | 32. REGISTRAR'S SIGNATURE<br><i>J. Davidson-Randall</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 3146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

14 28 (94) (94)

11

11 28

17

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for the funeral, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR   |  |  |   | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 90 26956  |  |   |  |
|---|--|--|---|---|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH  |  |  |   | REG. NO.  |  |  |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>HAMILTON GORDON WALKER  |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09/27/90  |  | 3. TIME OF DEATH<br>M  |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>705-09-1660  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>79 YRS. | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>06/07/11  | 8. BIRTHPLACE (State or Foreign Country)<br>Baltimore MD |  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>St. Agnes Hospital  |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE, MD. 21229   |  | 9c. COUNTY OF DEATH  |  |   |  |   |  |
| 10a. STATE<br>MD  |  |  |   | 10b. COUNTY<br>Baltimore  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE, MD 21228                                   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br>707 Maiden Choice #9110   |  |  |   | 10f. ZIP CODE<br>21228  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>4 years  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Civil Engineer                  |   | 16b. KIND OF BUSINESS/INDUSTRY<br>Engineering   |  |  |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Hamilton Walker   |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Elsie Atkinson   |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mrs. Mary Walker  |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>707 Maiden Choice Lane, Baltimore MD 21228   |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Greenmount Crematory   |   | 20c. LOCATION — City or Town, State<br>Baltimore, MD  |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Sherman Denny Jr.  |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Mitchell-Wiedefeld Home Inc.<br>6500 York Road, Baltimore Md. 21212   |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. PULMONARY EDEMA AND POSSIBLE DIFFUSE ALVEOLAR DAMAGE (ARDS)<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. ARTERIOLAR NEPHROSCLEROSIS WITH RENAL FAILURE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |   |   |  |  |  | Approximate interval between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>LARGE HEPATIC ADENOMA.<br>KYPHOSCOLIOSIS WITH VERTEBRAL COLLAPSE.   |  |  |   |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | HOSPITAL:<br>1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA             |   | OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 26. PLACE OF DEATH (Check only one)  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>William E. Kicken, M.D.   |   | 29c. LICENSE NUMBER<br>D04964   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/28/90                                       |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>ST. AGNES HOSPITAL 900 S. CATON AVENUE 21229   |  |  |   |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |   |   |  |  |  |   |  |   |  |



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>REGINA BERNADETTE WISE   |  |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 30 YEAR 90  |  | 3. TIME OF DEATH<br>3:31 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>212-07-3364   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>70 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>March 23 1920  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Baltimore  |  |  |  | 9. FACILITY NAME (If not institution, give street and number)<br>540 Parksley Avenue  |  | 10. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City  |  |
| 11. RESIDENCE OF DECEDENT<br>10a. STATE<br>MD  |  |  |  | 10b. COUNTY<br>BALTIMORE  |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE   |  |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br>540 PARKSLEY AVENUE   |  | 10f. ZIP CODE<br>21223   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>WHITE   |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>10th GRADE  |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>HOMEMAKER   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  | 17. FATHER'S NAME (First, Middle, Last)<br>CHARLES BAILEY  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>ROSE MURPHY   |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br>DENNIS WISE   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>880 WINDRIDER DRIVE, SYKESVILLE, MD. 21784  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>LONDON PARK CEMETERY  |  | 20c. LOCATION — City or Town, State<br>BALTIMORE   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Jackie D. Shannon</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>HUBBARD FUNERAL HOME INC.<br>4107 WILKENS AVENUE, BALTIMORE, MD. 21229  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>INSPECTION  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>XX YES 2 <input type="checkbox"/> NO   |  |  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> ODA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>XXXX Natural 6 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)                                      |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER<br>(Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Ann M. Dixon</i>   |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>10-1-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ann M. Dixon, M.D., Deputy Chief, 111 Penn Street, Baltimore, MD 21201 vl   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 03 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Gina Davidson-Rendell</i>   |  |  |  |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH REG. NO.

REG. NO.

|  |  |  |  |  |  |  |  |   |  |   |  |   |  |  |  |
|--|--|--|--|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Pauline WHALEN</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>9</i> DAY <i>30</i> YEAR <i>90</i>  |  |  |  | 3. TIME OF DEATH<br><i>100 A</i>  |  |   |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>213 367 503</i>  |  |  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>73</i> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>12-18-1916</i>  |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>MARYLAND</i> |  |   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Mercy Medical Center</i>  |  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore, Md.</i>   |  |   |  | 9c. COUNTY OF DEATH   |  |   |  |  |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |  |  |   |  |   |  |   |  |  |  |
| 10a. STATE<br><i>MARYLAND</i>  |  |  |  | 10b. COUNTY  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><i>BALTIMORE</i>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><i>713 S. BOND STREET</i>  |  |  |  |  |  |  |  | 10f. ZIP CODE<br><i>21231</i>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>WHITE</i>                            |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12 YEARS</i> College (1-4 or 5+) <i>HOMEMAKER</i>  |  |  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><i>HOMEMAKER</i>               |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY                              |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>LOUIS REMOFF</i>   |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>IDA KARCHER</i>  |  |   |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>MR. ALBERT WHALEN</i>   |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>223 VIRGINIA AVENUE BALTO. MD. 21221</i> |  |   |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>BALTIMORE NAT'L CEMETERY</i>  |  |  |  | 20c. LOCATION — City or Town, State<br><i>BALTO. MD.</i>  |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Raymond L. Kaczorowski</i>   |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>KACZOROWSKI FUNERAL HOME<br/>2525 FLEET STREET BALTO. MD. 21224</i>                                   |  |   |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Respiratory failure &amp; severe resp. acidosis</i><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>b. lung cancer</i><br><i>c. and probable sepsis</i><br><i>d.</i> |  |  |  |  |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED                           |  |   |  |  |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>J. Nimmerlich M.D.</i>   |  |  |  |  |  | 29c. LICENSE NUMBER  |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>9/30/90</i>       |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>T. Nimmerlich M.D. 301 St. Paul Pl. Balt. Md. 21230</i>  |  |  |  |  |  |  |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><i>OCT 03 1990</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>   |  |  |  |   |  |   |  |   |  |  |  |



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90-26959

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Ruth Brown   |  |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 28 YEAR 90  |  | 3. TIME OF DEATH<br>6:43 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>218-22-2133   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>60 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>6 17 30                                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>527 N. Pulaski St.  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City                                |  |
| 9c. COUNTY OF DEATH  |  |  |  | 10a. STATE<br>MD  |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 10e. STREET AND NUMBER<br>527 N. Pulaski Street  |  |  |  | 10f. ZIP CODE<br>21223  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>Black                  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>7th   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Domestic Work   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Wallace C Arberry   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Teresa Payton  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Dorothy Merritt  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6 Stuart Mills Place, Catonsville, MD 21228  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery  |  | 20c. LOCATION — City or Town, State<br>Glen Burnie, MD  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>March Funeral Home-West<br>4300 Wabash Avenue   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |  |  |
| Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.   |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Chronic Alcoholism   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/29/90                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Mario F. Golle, Jr., M.D. 111 Penn St. Baltimore, Md. 21201   |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 04 1990   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 of this form is to be completed by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26960

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Henry H. Allen   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9-27-90   |  | 3. TIME OF DEATH<br>5:43PM M   |  |
| 4. SOCIAL SECURITY NUMBER<br>705-09-7169A  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>85 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>4-22-05                                    |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>S.C.   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>2000 O'Dell Avenue  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City                                |  |
| 9c. COUNTY OF DEATH  |  |  |  | 10a. STATE<br>MD  |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br>BALTIMORE, CITY   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 10e. STREET AND NUMBER<br>2000 O'DELL AVE. APT-1509  |  |  |  | 10f. ZIP CODE<br>21237  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK                     |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>3rd   |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>CONSTRUCTION  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>ROBERT ALLEN  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MARY JANE  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>MARLENE ALLEN  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1424 N. BOND ST.-BALTIMORE, MD. 21213  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>CEDAR HILL CEMETERY  |  | 20c. LOCATION — City or Town, State<br>ANNE ARUNDEL CO, MD  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Wesley Coad</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>WM.C. MARCH F.H. 1101 E. NORTH AVE.   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |  | Approximate Interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypertensive arteriosclerotic cardiovascular disease<br>DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.  |  |  |  |   |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | INSPECTION  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Mario F. Golle, Jr.</i>  |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-28-90                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>MARIO F. GOLLE, JR., MD 111 Penn Street, Baltimore, MD 21201  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 04 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 2 weeks after death. Pages 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



90-5477

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 22961

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Andre Brisbon   |  |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 29 YEAR 90  |  | 3. TIME OF DEATH<br>9:54 P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>218-82-1430  |  | 6. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>20 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>11-5-69   |  |
| 9a. FACILITY NAME (If not Institution, give street and number)<br>Francis Scott Key Medical Center  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City  |  |   |  | 9c. COUNTY OF DEATH<br>MD   |  |
| 10a. STATE<br>MD  |  |  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br>BALTIMORE, CITY  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br>533 E. 23RD STREET  |  |   |  |
| 10f. ZIP CODE<br>21218  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK                            |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 9th<br>College (1-4 or 5+) _____  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>UNEMPLOYED                  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>BENNIE BRISBON   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>BETTY WALLER   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>BENNIE BRISBON  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>RT-1 BOX 204 -VELAND, N.C. 28451   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MT. ZION CEMETERY  |  | 20c. LOCATION — City or Town, State<br>LANDSDOWNE, MD.  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>WM.C. MARCH F.H. 1101 E. NORTH AVE.   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gunshot Wound of Neck<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)<br>9/29/90  |  | 28b. TIME OF INJURY<br>9:10P M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br>Subject was shot   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>on street  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>6300 Blk. Toone St., Balto. City, Md.   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br>OCME   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/30/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ann M. Dixon, M.D. 111 Penn St. Baltimore, Md. 21201   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 04 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 38146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10796. 00



**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

90 26962

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Helen Catherine Becker</b>  |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>02</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>10:15 A. M.</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>218-07-4783</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>69</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>12 02 20</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Md.</b>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>447 South Drew Street</b>   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |   |  |
| 10a. STATE<br><b>Md.</b>   |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br><b>447 South Drew Street</b>   |  |  |  | 10f. ZIP CODE<br><b>21224</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                                   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b></b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housework</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>At Home</b>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Theodore Jachelski</b>   |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Lillian</b>                                       |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Joan Hildon</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1931 Triway Houston, Texas 77043</b>  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Oak Lawn Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b>  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Charles S. Zeiler</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Charles S. Zeiler &amp; Son Inc. 6224 Eastern Ave.</b>   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiorespiratory arrest due to generalized carcinomatosis 9 months</b>   |  |  |  |   |  |   |  |   |  |
| SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. ENTER UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>{<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><b>From carcinoma of the left breast with widespread metastases</b><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.  |  |  |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>none</b>  |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> ODA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <b></b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>[Signature] M.D.</b>  |  | 29c. LICENSE NUMBER<br><b>D 17944</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>10/3/90</b>   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Dr. A. Shafik 7801 York Road S 100 Towson, Md. 21204</b>   |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 04 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 3146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed by the attending physician or other qualified person within 72 hours after death with this certificate has been signed by the attending physician or other qualified person, it is to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26963

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>FLORENCE P BECKETT</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>9 30 90</b>  |  | 3. TIME OF DEATH<br>P<br><b>7:12</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>250-30-2395</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9-16-1916</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>SOUTH CAROLINA</b>  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>CHURCH HOSPITAL</b>  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>  |  |
| 9c. COUNTY OF DEATH  |  |   |  | 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>1805 N SMALLWOOD ST.</b>  |  |
| 10f. ZIP CODE<br><b>21216</b>  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>CHEF</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>LAKE CITY COUNTRY CLUB</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>FRANCISCO BECKETT</b>  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>PAULINE JONES</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>DELORES M. LASHLEY</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1805 N. SMALLWOOD ST BALTIMORE, MD. 21216</b>   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>GOOD HOPE BAPTIST CURCH CEMSOUTH CAROLINA</b>  |  | 20c. LOCATION — City or Town, State<br><b>HAMPTON COUNTY</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>NUTTER FUNERAL HOMES, INC</b><br><b>2501 GWYNNS FALLS PKWY BALTO.MD 21216</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA COSTOVERTEBRAL ANGLE CYST</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>CONJESTIVE HEART FAILURE</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>CONJESTIVE HEART FAILURE</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>d.<br>DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br><br><br>   |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>R. Hajj, M.D. R. HAJJ</b>  |  |   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9, 30, 90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>CGURCH HOSPITAL R. HAJJ MD.</b>  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 4 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100

100

**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

90 26964

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |   |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>VIVIAN C. BONNER</b>  |  |   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>29</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>12:00 p</b> M  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>214-54-4722</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>44</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>June 27 1946</b>   |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>                                     |   |
| 9. FACILITY NAME (If not institution, give street and number)<br><b>St AGNES HOSPITAL</b>  |  |   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE CITY</b>  |  | 9c. COUNTY OF DEATH   |   |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |   |  |   |   |
| 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br><b>4120 POTTER ST</b>  |  |   |  | 10f. ZIP CODE<br><b>21229</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |   |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  |   |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>CLERK</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>UNIVERSITY OF MARYLAND<br/>SHOCK-TRAUMA UNIT</b>                           |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>NATHANIEL BONNER</b>   |  |   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>SARAH MC CALL</b>                                       |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>SARAH M. BONNER</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2331 W. LEXINGTON ST BALTO, MD. 21223</b>   |  |   |  |   |   |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>INTERMENT</b>  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>METRO CREMATORY</b>  |  |   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MARYLAND</b>   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>NUTTER FUNERAL HOMES, INC<br/>2501 GWYNNS FALLS PKWY BALTO, MD 21216</b> |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Multi-Organ Failure.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. METICILLIN - RESISTANT STAPH. Aureus Sepsis.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c. MRSA PERITONITIS / BACTERIAL ENDOCARDITIS</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d. SEPTIC EMBOLIC STROKE.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC RENAL FAILURE ON CAPD<br/>DIABETES MELLITUS</b>   |  |   |  |   |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   |  |   |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |   |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO                     |  | 28d. DESCRIBE HOW INJURY OCCURRED   |   |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |   |   |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>KORA, M.D.</b>   |  |   |  |   |  | 29c. LICENSE NUMBER<br><b>RESIDENT</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/29/90</b>   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>KORA, I. O., St. Agnes Hospital 900 CATON AV, BALTO. MD 21229.</b>   |  |   |  |   |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 4 1990</b>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26965

|   |  |   |  |   |   |   |   |   |  |  |
|---|--|---|--|---|---|---|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Robert Baskerville, Jr</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>3</b> YEAR <b>90</b>   |   | 3. TIME OF DEATH<br><b>5:20 A.M.</b>  |   |   |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>220-36-0403</b>   |  | 5. SEX<br><b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (in yrs. last birthday)<br><b>48</b> YRS.  |   | 7. DATE OF BIRTH (Month, Day, Year)<br><b>7/16/42</b>                                       |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b> |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Sinai Hospital</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |   |   | 9c. COUNTY OF DEATH<br><b>Baltimore</b>   |   |  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Lockhern</b>  |   |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |   |  |  |
| 10e. STREET AND NUMBER<br><b>4312 Danlou Drive</b>  |  |   |  | 10f. ZIP CODE<br><b>21207</b>   |   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |   |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |   |   | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                               |   |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Section Chief</b>  |  |   | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. Government Social Security Admin.</b> |   |   |   |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Robert Baskerville, Sr.</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Doris Harley</b>  |   |   |   |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Ethel Baskerville</b>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4312 Danlou Drive Baltimore, MD 21207</b>   |   |   |   |   |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Woodlawn Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Baltimore Co., MD</b>   |   |   |   |   |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Herbert E. Nutter</b>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Nutter Funeral Homes, 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>  |   |   |   |   |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Metastatic lung CA</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. Coc. pulmonale</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br><b>d.</b> |  |   |  |   |   |   | Approximate Interval Between Onset and Death  |   |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |   |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |   |   |   |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED                           |  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |   |   |   |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |   |   |   |   |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Sally Young MD PGY-1</b>  |  |   |  | 29c. LICENSE NUMBER   |   | 29d. DATE SIGNED (Month, Day, Year)<br><b>10/3/90</b>                                       |   |   |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Sally Young Sinai Hospital</b>  |  |   |  |   |   |   |   |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 4 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Henderson</b>   |   |   |   |   |  |  |

64-31-1

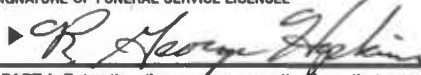






1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26966

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>JOAN LORRAINE DEVANEY BYRD   |  |  |  | 2. DATE OF DEATH<br>MONTH 9 DAY 30 YEAR 90   |  | 3. TIME OF DEATH<br>P M  |  |
| 4. SOCIAL SECURITY NUMBER<br>161-28-4819   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>54 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>June 9, 1936  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>PENNSYLVANIA   |  |  |  | 9. FACILITY NAME (If not institution, give street and number)<br>574 Valleywood Road   |  | 10. CITY, TOWN OR LOCATION OF DEATH<br>Millersville  |  |
| 11. COUNTY OF DEATH<br>Anne Arundel  |  |  |  | 12. STATE<br>MARYLAND  |  | 13. COUNTY<br>ANNE ARUNDEL   |  |
| 14. CITY, TOWN OR LOCATION<br>MILLERSVILLE   |  |  |  | 15. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 16. STREET AND NUMBER<br>574 Valleywood Rd   |  |
| 17. ZIP CODE<br>21108  |  |  |  | 18. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 19. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced |  |
| 20. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 22. RACE — American Indian, Black, White, etc.<br>Specify: WHITE   |  |
| 23. DECEASED'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 4  |  |  |  | 24. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>MARKETING SPECIALIST  |  | 25. KIND OF BUSINESS/INDUSTRY<br>CHESAPEAKE HEALTH PLAN  |  |
| 26. FATHER'S NAME (First, Middle, Last)<br>JOHN F. DEVANEY   |  |  |  | 27. MOTHER'S NAME (First, Middle, Maiden Surname)<br>CATHRYN L COLEMAN   |  |  |  |
| 28. INFORMANT'S NAME (Type/Print)<br>Ms. Darryl L. Byrd  |  |  |  | 29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>938 Calvert St. 1F Baltimore, MD 21202   |  |  |  |
| 30. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 31. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>METRO CREAMATORY INC.   |  | 32. LOCATION — City or Town, State<br>BALTIMORE, MD  |  |
| 33. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 34. NAME AND ADDRESS OF FACILITY<br>SINGLETON FUNERAL HOME<br>1 Second Ave. S.W. GlenBurnie, MD 21061  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Contact Gunshot Wound of Head<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |  |  |  |  |
| b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>(Head only)   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)<br>Found 9-30-90/4:00 P   |  |  |  |
| 28b. TIME OF INJURY<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |
| 28d. DESCRIBE HOW INJURY OCCURRED<br>Subject shot self   |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>home   |  |  |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br>574 Valleywood Road, Millersville, Anne Arundel  |  |  |  | 28g. COUNTY, MD  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  | 29c. LICENSE NUMBER<br>OCME  |  | 29d. DATE SIGNED (Month, Day, Year)<br>10-1-90   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Ann M. Dixon, M.D., Deputy Chief 111 Penn Street, Baltimore, MD 21201 vl  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 04 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 3346,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

012-5 02

1000 1000 1000 1000

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90-26967

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ROBERT CLEMENT</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>23</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>3:36 A M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>325-03-5649</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>75 YRS.</b>  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>07-08-15</b>                                      |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Good Samaritan Hosp.</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balto.</b>  |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br><b>Md.</b>   |  |  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>Balto.</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>5612 Woodmount Ave.</b>  |  |   |  |
| 10f. ZIP CODE<br><b>21239</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |
| 11. MARITAL STATUS<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Viola Bauernshub</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4426 Black Rock Hampstead, Md. 21074</b>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>In-state rem.</b>   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  | 20c. LOCATION — City or Town, State   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i> <b>10-2-90</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board Balto. Md.</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardiopulmonary arrest</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>inferior MI</b><br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>pulmonary edema</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Wail Amy PAY II</i>  |  |  |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/23/90</b>                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>WAIL ASSY GOOD SAMARITAN HOSP.</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>9/23/1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. DECEDENT'S NAME (First, Middle, Last)  |  |   |                                | 2. DATE OF DEATH<br>MONTH DAY YEAR  |  |  |  | 3. TIME OF DEATH  |  |
|---|--|---|--------------------------------|---|--|--|--|---|--|
| Alan Collins  |  |   |                                | 09 27 90  |  |  |  | 1:35 M  |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX  | 6. AGE (In yrs. last birthday) | 7. DATE OF BIRTH<br>(Month, Day, Year)  |  | 8. BIRTHPLACE (State or Foreign Country)                                     |  |   |  |
| 216-54-2745   |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 39 YRS.                        | 11/23/1950  |  | Maryland   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |   |                                | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |  |  | 9c. COUNTY OF DEATH   |  |
| Liberty Medical Center  |  |   |                                | Baltimore   |  |  |  |   |  |
| 10a. STATE  |  | 10b. COUNTY   |                                | 10c. CITY, TOWN OR LOCATION   |  |  |  | 10d. INSIDE CITY LIMITS?  |  |
| Maryland  |  |   |                                | Baltimore   |  |  |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO     |  |
| 10e. STREET AND NUMBER  |  |   |                                | 10f. ZIP CODE   |  | 10g. CITIZEN OF WHAT COUNTRY?  |  |   |  |
| 130 Stonecroft Road   |  |   |                                | 21229   |  | U. S. A.   |  |   |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?   |                                | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) |  | 14. RACE — American Indian, Black, White, etc. Specify:                      |  |   |  |
| 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |                                | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:                                       |  | Black  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)   |                                | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |   |  |
| Elementary/Secondary (0-12) College (1-4 or 5+)   |  | Teacher   |                                | Dept. of Education<br>Balto. City Schools   |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |   |                                | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |  |  |   |  |
| Ronald A. Addison   |  |   |                                | Ruth E. Collins   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |   |                                | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)               |  |  |  |   |  |
| Ruth E. Collins   |  |   |                                | 3622 W. Forest Park Ave. Balto. MD 21216  |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)  |                                | 20c. LOCATION — City or Town, State   |  |  |  |   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | Druid Ridge Cemetery  |                                | Baltimore, Maryland   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |   |                                | 22. NAME AND ADDRESS OF FACILITY  |  |  |  |   |  |
| Herbert E. Nutter   |  |   |                                | Nutter Funeral Homes,<br>2501 Gwynns Falls Parkway<br>Baltimore, Maryland 21216                             |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |                                |   |  |  |  | Approximate Interval Between Onset and Death                                |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  | a. pneumonia  |                                |   |  |  |  |   |  |
|   |  | b. Seizure disorder   |                                |   |  |  |  |   |  |
|   |  | c. Renal failure  |                                |   |  |  |  |   |  |
|   |  | d. Acquired Immune deficiency Syndrome  |                                |   |  |  |  |   |  |
| 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |                                |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?  |  |
| Cardio-pulmonary arrest<br>anemia   |  |   |                                |   |  |  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  | 26. PLACE OF DEATH (Check only one)   |                                |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |   |  |  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 27. MANNER OF DEATH   |  | 28a. DATE OF INJURY (Month, Day, Year)  |                                | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  |   |                                | M   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                 |  |   |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |                                |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |   |  |
|   |  |   |                                |   |  |  |  |   |  |
| 29a. CERTIFIER (Check only one)   |  |   |                                |   |  |  |  | 29c. LICENSE NUMBER   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                                |   |  |  |  | D30115  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |   |                                | 29d. DATE SIGNED (Month, Day, Year)   |  |  |  |   |  |
| T. O. HOKPEHAI, MD  |  |   |                                | 9/27/90   |  |  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |   |                                |   |  |  |  |   |  |
| T. O. HOKPEHAI, MD 2600 LIBERTY HTS AVE. BALTO. MD 21215  |  |   |                                |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)   |  |   |                                | 32. REGISTRAR'S SIGNATURE   |  |  |  |   |  |
| OCT 4 1990  |  |   |                                | Julia Davidson-Randall  |  |  |  |   |  |

000000 00

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26969

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>NUTT CLAYTON</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>09</b> DAY <b>30</b> YEAR <b>90</b>  |  | 3. TIME OF DEATH<br><b>3:30 A</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>215-28-3706</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>YRS. MONTHS DAYS  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>1/2/34</b>   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Home - 1637 Westwood Avenue</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE, MD 21217</b>   |  | 9c. COUNTY OF DEATH<br><b>BALTIMORE CITY</b>   |   |
| 10a. STATE<br><b>Maryland</b>   |  |  |  | 10b. COUNTY<br><b>Baltimore</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>  |   |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><b>1637 Westwood Ave</b>  |  |  |   |
| 10f. ZIP CODE<br><b>21217</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Dept. of Public Works</b>   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Clayton Nutt</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Nellie Young</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Anna M. Eveline</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1637 Westwood, Baltimore, MD. 21217</b>   |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt Zion Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Balto., MD</b>  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Charlene A. Brown</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Joseph H. Brown F.H., P.O. Box 4433<br/>Baltimore, MD. 21223</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><b>a. RUPTURED Abdominal Aortic Aneurysm</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Hypertension or Mycotic Aneurysm</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>HIV positive secondary to Intravenous Drug Use</b><br><b>End stage Renal Disease</b><br><b>Hepatitis B positive</b> |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>4 months</b><br><b>Hypertension - 10 years</b>     |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HIV positive secondary to Intravenous Drug Use</b><br><b>End stage Renal Disease</b><br><b>Hepatitis B positive</b>  |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>09/30/90</b>  |   |
| 28b. TIME OF INJURY<br><b>3:30 A</b>  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><b>In Bathroom - Slipping - probably ruptured Aneurysm</b>   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br><b>home 1637 Westwood Avenue</b> |   |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)<br><b>BALTIMORE, MD 21217</b>  |  | 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Robert C Greenwell MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D34334</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>10/1/90</b>  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Robert C Greenwell Jr MD 900 Calum Avenue BALTIMORE, MD 21223</b>   |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 04 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Johanna Davidson-Randall</b>  |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. After filing, the original certificate should be retained by the funeral director, or removed. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

50000000



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be retained for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| FOR STATE REGISTRAR  |  |   |                                | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 90 26970  |  |
|--|--|---|--------------------------------|--|--|---|--|---|--|
| 1. DECEDECENT'S NAME (First, Middle, Last)   |  |   |                                | 2. DATE OF DEATH   |  |   |  | 3. TIME OF DEATH  |  |
| KATIE DICKERSON  |  |   |                                | MONTH 10 DAY 01 YEAR 90  |  |   |  | 13 25 M   |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX  | 6. AGE (In yrs. last birthday) | 7. DATE OF BIRTH   |  | 8. BIRTHPLACE (State or Foreign Country)                                |  |   |  |
| 221 03 7059  |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 89 YRS.                        | 03/15/01   |  | Pennsylvania  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)   |  |   |                                | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |   |  | 9c. COUNTY OF DEATH   |  |
| UNION MEMORIAL HOSPITAL  |  |   |                                | BALTIMORE CITY   |  |   |  |   |  |
| 10a. STATE   |  | 10b. COUNTY   |                                | 10c. CITY, TOWN OR LOCATION  |  | 10d. INSIDE CITY LIMITS?  |  |   |  |
| Maryland   |  | Baltimore County  |                                | Essex  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |
| 10e. STREET AND NUMBER   |  |   |                                | 10f. ZIP CODE  |  | 10g. CITIZEN OF WHAT COUNTRY?   |  |   |  |
| 1925 Cape May Road   |  |   |                                | 21221  |  | USA   |  |   |  |
| 11. MARITAL STATUS   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?   |                                | 13. WAS DECEDENT OF HISPANIC ORIGIN?   |  | 14. RACE — American Indian, Black, White, etc.                          |  |   |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES          |                                | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>Specify:  |  | Specify:<br>White   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.) |                                | 16b. KIND OF BUSINESS/INDUSTRY   |  |   |  |   |  |
| Elementary/Secondary (0-12)<br>8   |  | College (1-4 or 5 +)<br>Housewife   |                                | HOME   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |   |                                | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |   |  |   |  |
| James Miller   |  |   |                                | Mary Jane Heaps  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |   |                                | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |   |  |   |  |
| Arthur R. Dickerson (son)  |  |   |                                | 1925 Cape May Road Baltimore Maryland 21221  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)  |                                | 20c. LOCATION — City or Town, State  |  |   |  |   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | Oak Lawn Cemetery   |                                | Baltimore, Maryland  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |   |                                | 22. NAME AND ADDRESS OF FACILITY   |  |   |  |   |  |
| <i>Richard B. Bynum</i>  |  |   |                                | Bruzdinski Funeral Home P.A.<br>1407 Old Eastern Ave. Balto., Md 21221   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Respiratory Failure</u><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. <u>Sepsis</u><br>c. <u>Sacral Decubitus ulcer</u><br>d. <u></u> |  |   |                                |  |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Hx Adenocarcinoma of Colon, Hypertension, Peptic Ulcers, Hx of C2 Fracture.</u>   |  |   |                                |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |                                |  |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 26. PLACE OF DEATH (Check only one)  |  |   |                                | 27. MANNER OF DEATH  |  |   |  |   |  |
| HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |                                | 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |   |  |   |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY   |                                | 28c. INJURY AT WORK?   |  | 28d. DESCRIBE HOW INJURY OCCURRED                                       |  |   |  |
|  |  | M   |                                | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |                                | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
|  |  |   |                                |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |                                |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>D. Schellberg</i>  |  |   |                                | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)                                     |  |   |  |
|  |  |   |                                |  |  | 10/1/90   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |   |                                |  |  |   |  |   |  |
|  |  |   |                                |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)  |  |   |                                | 32. REGISTRAR'S SIGNATURE  |  |   |  |   |  |
| OCT 04 1990  |  |   |                                | <i>John Davidson-Randell</i>   |  |   |  |   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 90 26971  |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>TEREMEZIA C. DORSEY   |  |  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>09 30 90                                       |  | 3. TIME OF DEATH<br>9 50 P.M.  |  |
| 4. SOCIAL SECURITY NUMBER<br>214-50-0452  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>43 YRS.  | 7. DATE OF BIRTH (Month, Day, Year)<br>06-16-47   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Md                                       |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>LIBERTY MEDICAL   |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE                                     |  | 9c. COUNTY OF DEATH  |  |
| 10a. STATE<br>MD  |  |  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER<br>1310 Myrtle Avenue  |  |  |  | 10f. ZIP CODE<br>21217  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: Black                     |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Unemployed |   |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Lonnie Greene Sr.  |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Corrina Graves                  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Veronica Vaughn   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1403 TownWay, Baltimore, MD 21202  |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Western Star Cemetery  |  | 20c. LOCATION — City or Town, State<br>Catonsville, MD  |  |  |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>March Funeral Home-West<br>4300 Wabash Avenue   |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HEPATO-RENAL SYNDROME<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. ALCOHOLIC LIVER DISEASE<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  |  | Approximate interval Between Onset and Death   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>SEIZURE DISORDER  |  |  |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>MD   |  |  |  | 29c. LICENSE NUMBER<br>D 23300  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9.30.90                                       |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>SUDHIR. PATEL 2600 Liberty Rd. BALTIMORE   |  |  |  |   |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 04 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |  |  |

CLASS 00

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician it is completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 90 26972  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |   |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Lillian Donovan</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10-2-1990</b>  |  |  |  | 3. TIME OF DEATH<br>M<br><b>2:20 A</b>  |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>580-19-7585</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>56</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>09-21-34</b> |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>TORTOLA</b> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Hartford Mem. Hosp</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hartford de Grace</b>   |  |  |  | 9c. COUNTY OF DEATH<br><b>Hartford</b>  |  |   |  |  |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>EDGEWOOD</b>   |  | 10c. CITY, TOWN OR LOCATION   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |  |  |
| 10e. STREET AND NUMBER<br><b>522 CANDLEWOOD DRIVE</b>  |  |  |  | 10f. ZIP CODE<br><b>21040</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>BLACK</b>                          |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>5th</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>UNEMPLOYED</b>               |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>WILLIAM BARRY</b>  |  |  |  | 16. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>AUGUSTA MARS</b>  |  |  |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>CLORETT HUTCHINSON</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>522 CANDLEWOOD DR.-EDGEWOOD, MD 21040</b>   |  |  |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>PLEASANT VALLEY CEMETERY</b>  |  | 20c. LOCATION — City or Town, State<br><b>VIRGIN ISLAND</b>   |  |  |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Lanessa Coad</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>  |  |  |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>BVA</b><br><br>Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>ASPER</b><br><br>a. DUE TO (OR AS A CONSEQUENCE OF):<br><br>b. DUE TO (OR AS A CONSEQUENCE OF):<br><br>c. DUE TO (OR AS A CONSEQUENCE OF):<br><br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |  |  |   |  |  |  |   |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | HOSPITAL:<br>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA                        |  | OTHER:<br>4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 26. PLACE OF DEATH (Check only one)  |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident<br>3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURED  |  |   |  |  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |   |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |  |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>J. Lee</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D20661</b>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>10/2/90</b>   |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>J. Lee 319 S. Union Ave Hartford de Grace</b>  |  |  |  |   |  |  |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 04 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Rendell</b>   |  |  |  |   |  |   |  |  |  |



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26973

|  |  |  |   |   |  |  |   |
|--|--|--|---|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MAY Viola Dahm   |  |  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>Oct. 02 90  |  | 3. TIME OF DEATH<br>P M<br>1730 P M  |   |
| 4. SOCIAL SECURITY NUMBER<br>215-01-3002   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 6. AGE (In yrs. last birthday)<br>90 YRS. |   | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>May 28, 1900 |  | 8. BIRTHPLACE (State or Foreign Country)<br>Balt. Md. |
| 9a. FACILITY NAME (If not institution, give street and number)<br>NORTH ARUNDEL HOSPITAL   |  |  |   | 9b. CITY, TOWN OR LOCATION OF DEATH<br>GLEN BURNIE MD. 21061  |  | 9c. COUNTY OF DEATH<br>ANNE ARUNDEL  |   |
| 10a. STATE<br>Md.  |  | 10b. COUNTY<br>Anne Arundel  |   | 10c. CITY, TOWN OR LOCATION<br>Glen Burnie  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |   |
| 10e. STREET AND NUMBER<br>314 Roosevelt Ave.   |  |  |   | 10f. ZIP CODE<br>21061  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |   | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: white   |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 6 College (1-4 or 5+) none   |  |  |   | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Cook   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Cater  |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>Ricard Oliver Bowersox  |  |  |   | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Martha Elizabeth Trimper   |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>George O. Heinritz   |  |  |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>314 Rosevelt Ave. Glen Burnie Md. 21061  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Meadowridge Memorial Park  |   | 20c. LOCATION — City or Town, State<br>Elkridge, Md.  |  |  |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Harold B. Bowersox</i>   |  |  |   | 22. NAME AND ADDRESS OF FACILITY<br>Singleton Funeral Home<br>1 Second Ave S.W. Glen Burnie, Md. 21061  |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>acute myocardial infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>atherosclerotic cardiovascular disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |   |   |  | Approximate Interval Between Onset and Death<br>Immed.<br>years  |   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>pulmonary emboli</i>  |  |  |   |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |   |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |   | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |   |
|  |  | 28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |   |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Joe E. Kadian MD</i>   |  |  |   | 29c. LICENSE NUMBER<br>AK9630016  |  | 29d. DATE SIGNED (Month, Day, Year)<br>10/2/90   |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>IRA KAPLAN M.D. 7845 OAKWOOD RD. GLEN BURNIE MD 21061   |  |  |   |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br>OCT 04 1990   |  |  |   |   |  |  |   |

111111

111111

2



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for filing in the State Register of Deaths.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH90 26974  
REG. NO.

|  |  |  |  |   |  |   |   |   |  |
|--|--|--|--|---|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>ETHEL SCESCO DOWE</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>30</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>9 PM</b> M   |   |   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>577-03-9444-A</b>  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>84</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>7/05/06</b>  |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>DC</b>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>7600 Fountain Blue Drive #709</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>New Carrollton</b>  |  |   | 9c. COUNTY OF DEATH<br><b>Prince George</b>   |   |  |
| 10a. STATE<br><b>MD</b>  |  | 10b. COUNTY<br><b>Prince George</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>New Carrollton</b>  |  |   | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br><b>7600 Fountain Blue Drive #709</b>   |  |  |  | 10f. ZIP CODE   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |   |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                                   |   |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><b>Unk</b>  |  | 15a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>  |  | 16. KIND OF BUSINESS/INDUSTRY   |  |   |   |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph Scesco</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Charlotte Willis</b>  |  |   |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Oscar Scesco</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Upper Marlboro, Md</b>  |  |   |   |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Park</b>   |  | 20c. LOCATION — City or Town, State<br><b>Landover, Md</b>  |  |   |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Juan Smith</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>John T Rhines Co., Inc<br/>3015 12th St NE, DC 20017</b>   |  |   |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Myocardial Infarction</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>b. Atherosclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>c.</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  | Approximate Interval Between Onset and Death<br><b>minutes</b><br><b>years</b>                            |   |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)<br><b>NIA</b>   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |   | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Paul A. DeVore MD</b><br><b>Deputy Medical Examiner</b>  |  |  |  | 29c. LICENSE NUMBER<br><b>201852</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>10/1/90</b>   |   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Paul A. DeVore MD 4203 Greenbury Rd Hyattsville MD 20781</b>   |  |  |  |   |  |   |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 04 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Julia Davidson-Randall</b>  |  |   |   |   |  |

1944

1944

1944

1944

1944

1944

DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



|  |  |  |  |   |  |   |   |   |  |  |
|--|--|--|--|---|--|---|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>DANIEL ROBERT DINKO, SR.</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>OCT. 2 1990</b>  |  | 3. TIME OF DEATH<br><b>6:00 A. M.</b>   |   |   |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>164-26-8438</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>55</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Jan. 14 1935</b>                                  |   | 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b> |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>105 Oakleigh Ave.</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Ferndale</b>  |  |   | 9c. COUNTY OF DEATH<br><b>Anne Arundel</b>  |   |  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Anne Arundel</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Glen Burnie</b>   |  |   | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |   |  |  |
| 10e. STREET AND NUMBER<br><b>105 Oakleigh Ave.</b>   |  |  |  | 10f. ZIP CODE<br><b>21061</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |   |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>                            |   |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 12th</b>  |  | 16. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Vice President</b>  |  | 17. KIND OF BUSINESS/INDUSTRY<br><b>American Painting &amp; Dry Wall</b>  |  |   |   |   |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Andrew Dinko</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Anna Ballant</b>  |  |   |   |   |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Katherine R. Dinko</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>Same as 10</b>  |  |   |   |   |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Meadowridge Memorial Park</b>   |  |   | 20c. LOCATION — City or Town, State<br><b>Elkridge, Maryland</b> |   |   |   |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SINGLETON FUNERAL HOME</b><br><b>1 SECOND AVE. S.W., GLEN BURNIE, MD. 21061</b>  |  |   |   |   |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Metastatic Small Cell Carcinoma Lung</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>b. Cigarette Smoking</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>DUE TO (OR AS A CONSEQUENCE OF): |  |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>10 mos</b>   |   |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alcohol addiction</b><br><b>Alcoholic liver disease</b>   |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |   |   |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED                               |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |   |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |   |   |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  | 29c. LICENSE NUMBER<br><b>P38201</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>10/3/90</b>                                       |   |   |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Timothy J. Mounihan M.D. Johns Hopkins Oncology Center</b><br><b>600 N. Wolfe St. Onc 126 Baltimore 21205</b>  |  |  |  |   |  |   |   |   |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 04 1990</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |   |   |  |  |



1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26976

|   |  |   |  |   |
|---|--|---|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>THOMAS FOUSE</b>   |  | 2. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>1</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>4:09 A M</b>   |
| 4. SOCIAL SECURITY NUMBER<br><b>233-20-6149</b>   | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>1 2 19</b>                                 | 8. BIRTHPLACE (State or Foreign Country)<br><b>West Virginia</b>  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Sinai Hospital</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore City</b>  |  | 9c. COUNTY OF DEATH   |
| RESIDENCE OF DECEDENT   |  |   |  |   |
| 10a. STATE<br><b>MD</b>   | 10b. COUNTY  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |
| 10e. STREET AND NUMBER<br><b>3304 Devonshire Drive</b>  |  | 10f. ZIP CODE<br><b>21215</b>   | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |   |  |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Arrow Window Company</b>   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Willie Fouse</b>  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Christina Stable</b>  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Loretta Fouse</b>  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3304 Devonshire Drive, Balto., MD 21215</b>   |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Garrison Forest V.A. Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Owings Mills, MD</b>  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March Funeral Home-West<br/>4300 Wabash Avenue</b>   |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Prostate carcinoma</b>   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br><b>INSPECTION</b>  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |   |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide |  |   |
| 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO | 28d. DESCRIBE HOW INJURY OCCURRED   |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  | 29c. LICENSE NUMBER<br><b>OCME</b>  | 29d. DATE SIGNED (Month, Day, Year)<br><b>10-1-90</b>                                |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Ann M. Dixon, M.D., Deputy Chief 111 Penn Street, Baltimore, MD 21201 vl</b>  |  |   |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 04 1990</b>   |  |   |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

of 2001



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

90 26977

REG. NO.

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>MATTIE FREEMAN   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>9 28 90   |  | 3. TIME OF DEATH<br>5:08 P M   |  |
| 4. SOCIAL SECURITY NUMBER<br>216-36-9468   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (in yrs. last birthday)<br>55 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>10-20-34                              |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>VA.  |  |   |  | 9a. FACILITY NAME (If not institution, give street and number)<br>UNION MEMORIAL HOSPITAL   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE, CITY                       |  |
| 9c. COUNTY OF DEATH  |  |   |  | 10a. STATE<br>MD  |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br>BALTIMORE, CITY   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 10e. STREET AND NUMBER<br>2000 ODELL AVE. APT-1225   |  |   |  | 10f. ZIP CODE<br>21237  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>UNEMPLOYED   |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>NICHOLAS ASHER  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>STELLA FITZGERALD  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>PATRICIA FREEMAN   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3600 CLIFTON AVE.-BALTIMORE, MD. 21216   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>ARBUTUS MEMORIAL PARK   |  | 20c. LOCATION — City or Town, State<br>ARBUTUS, MD.   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Wm. C. March</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>WM.C. MARCH F.H. 1101 E. NROTH AVE.   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Acute Myocardial Infarction</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Seizure<br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. <u>Chronic Renal Failure</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>Diabetes |  |   |  |   |  |  | Approximate Interval Between Onset and Death   |
| PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I.<br><u>Severe coronary Artery disease</u><br><u>Urosepsis</u>   |  |   |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  |   |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  | 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide<br>3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Adriana Maldonado-Brem MD</i>  |  |   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>9-28-90                               |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>ADRIANA MALDONADO-BREM Union Memorial Hospital 201 E. Univ. BLVD BALTIMORE MD   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 04 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 3146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the attending physician or other qualified person within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or other qualified person, it must be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |   |  | REG. NO. 90 26978  |  |                                   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|--|--|-----------------------------------|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |  |  | 2. DATE OF DEATH  |  |   |  | 3. TIME OF DEATH   |  |                                   |  |   |  |   |  |
| Genevieve H. Fisher   |  |  |  | MONTH DAY YEAR<br>09 26 90  |  |   |  | 6:50 a M   |  |                                   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX   |  | 6. AGE (In yrs. last birthday)  |  | IF UNDER 1 YEAR   |  | IF UNDER 24 HRS.   |  | 7. DATE OF BIRTH                  |  | 8. BIRTHPLACE (State or Foreign Country)                                |  |   |  |
| 219-16-8688   |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F                                 |  | 66 YRS.   |  | MONTHS DAYS   |  | HOURS MIN.   |  | 12-09-23                          |  | Md.   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |  |  | 9c. COUNTY OF DEATH               |  |   |  |   |  |
| 2367 Carrollton Rd  |  |  |  |   |  | Westminister  |  |  |  | Carroll Co.                       |  |   |  |   |  |
| 10a. STATE  |  |  |  | 10b. COUNTY   |  |   |  | 10c. CITY, TOWN OR LOCATION  |  |                                   |  | 10d. INSIDE CITY LIMITS?  |  |   |  |
| Md.   |  |  |  | Carroll   |  |   |  | Westminister   |  |                                   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |
| 10e. STREET AND NUMBER  |  |  |  |   |  | 10f. ZIP CODE   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?     |  |   |  |   |  |
| 2367 Carrollton Rd.   |  |  |  |   |  | 21157   |  |  |  | U.S.A.                            |  |   |  |   |  |
| 11. MARITAL STATUS  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?  |  | 14. RACE  |  | 15. DECEDENT'S EDUCATION   |  | 16a. DECEDENT'S USUAL OCCUPATION  |  | 16b. KIND OF BUSINESS/INDUSTRY  |  |   |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>Specify:   |  | Specify: White  |  | Elementary/Secondary (0-12)<br>College (1-4 or 5+)                           |  | Repair Service                    |  | C&P Telephone   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |  |  |                                   |  |   |  |   |  |
| Cassell Haines  |  |  |  |   |  | Ethel Baker   |  |  |  |                                   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |  |  |  |                                   |  |   |  |   |  |
| Donald Fisher   |  |  |  |   |  | 21157<br>2367 Carrollton Rd. 21157 Westminister, Md   |  |  |  |                                   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)  |  |   |  | 20c. LOCATION — City or Town, State  |  |                                   |  |   |  |   |  |
| 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  |   |  |   |  |  |  |                                   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |  |  | 22. NAME AND ADDRESS OF FACILITY  |  |   |  |  |  |                                   |  |   |  |   |  |
| <i>Donny White 10-2-90</i>  |  |  |  | State Anatomy Board Balto. Md.  |  |   |  |  |  |                                   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |   |  |  |  |                                   |  | Approximate Interval Between Onset and Death                            |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |  |  |   |  |   |  |  |  |                                   |  |   |  |   |  |
| a. <i>Hypertensive Failure</i>  |  |  |  |   |  |   |  |  |  |                                   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |  |  |                                   |  |   |  |   |  |
| b. <i>Breast carcinoma</i>  |  |  |  |   |  |   |  |  |  |                                   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |  |  |                                   |  |   |  |   |  |
| c. <i></i>  |  |  |  |   |  |   |  |  |  |                                   |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |  |   |  |   |  |  |  |                                   |  |   |  |   |  |
| d. <i></i>  |  |  |  |   |  |   |  |  |  |                                   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |  |  |  |                                   |  | 24a. WAS AN AUTOPSY PERFORMED?  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |  |
|   |  |  |  |   |  |   |  |  |  |                                   |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  |  |  | 26. PLACE OF DEATH (Check only one)   |  |   |  |  |  |                                   |  |   |  |   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |  | HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |                                   |  |   |  |   |  |
| 27. MANNER OF DEATH   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY   |  | 28c. INJURY AT WORK?   |  | 28d. DESCRIBE HOW INJURY OCCURRED |  |   |  |   |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |  |   |  | M   |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                 |  |                                   |  |   |  |   |  |
|   |  |  |  | 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |                                   |  |   |  |   |  |
|   |  |  |  |   |  |   |  |  |  |                                   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)   |  |  |  |   |  |   |  |  |  |                                   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)   |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |  |  |                                   |  | 01462C  |  | 9/28/90   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |  |  |   |  |   |  |  |  |                                   |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |   |  |   |  |  |  |                                   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)   |  |  |  |   |  |   |  |  |  |                                   |  | 32. REGISTRAR'S SIGNATURE   |  |   |  |
| OCT 14 - 1990   |  |  |  |   |  |   |  |  |  |                                   |  | <i>Jake Davidson-Randall</i>  |  |   |  |

07033 02

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26979

|   |  |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>William J. Fortman, Jr.</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>10</i> / DAY <i>2</i> / YEAR <i>90</i>  |  | 3. TIME OF DEATH<br><i>5:55 AM</i>   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>215-16-9833 A</i>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><i>67</i> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>Aug. 30, 1923</i>                   |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i>   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Homewood Hospital Center, South</i>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Baltimore</i>  |  |  |  | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br><i>Maryland</i>   |  |  |  | 10b. COUNTY  |  |  |  | 10c. CITY, TOWN OR LOCATION<br><i>Baltimore City</i>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 10e. STREET AND NUMBER<br><i>2305 Hamilton Avenue</i>  |  |  |  | 10f. ZIP CODE<br><i>21214</i>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  |  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><i>WW II</i>  |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>   |  |  |  | 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i>College</i>   |  |
| 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Printer</i>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |  |  | 17. FATHER'S NAME (First, Middle, Last)<br><i>William J. Fortman</i>  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Nina B. Charnock</i>  |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br><i>Mrs. Nina B. Fortman</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2305 Hamilton Avenue, Baltimore, Maryland 21214</i>   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Garrison Forest State Vet. Cem. 10.5.90</i>   |  |  |  | 20c. LOCATION — City or Town, State<br><i>Baltimore Maryland</i>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Michael J. Ruck</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Leonard J. Ruck, Inc. 5305 Harford Road 21214</i>   |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br><i>a. Cardiac stroke</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>b. Acute Anterior Myocardial infarction</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>c. Atherosclerotic cardiovascular disease</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><i>d.</i><br><br>Approximate interval Between Onset and Death<br><i>4 HRS.</i><br><i>7 HRS.</i><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  |
| 28a. DATE OF INJURY (Month, Day, Year)  |  |  |  | 28b. TIME OF INJURY<br><i>M</i>  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Marion B. McKim M.D.</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>D15698</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>10/2/90</i>                            |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>MARCOS B. GALICIA M.D. Homewood Hospital Center, South. Balt, Md 21218</i>  |  |  |  | 31. DATE FILED (Month, Day, Year)<br><i>OCT 04 1990</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Julia Davidson-Randall</i>  |  |

STAGE 02

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26980

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ruth J. Grant</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>1</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>7 AM</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>243-32-9777</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>63</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>2-1-27</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>S.C.</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Liberty Medical Center</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Balto</b>  |  |
| 9c. COUNTY OF DEATH   |  |  |  | 10a. STATE<br><b>MD</b>   |  | 10b. COUNTY  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Balto</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO   |  | 10e. STREET AND NUMBER<br><b>3110 Belmont Ave</b>  |  |
| 10f. ZIP CODE<br><b>21216</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joe Hamp Johnson</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Estelle Epps</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Specify)<br><b>Lena Grant</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3110 Belmont Ave Balto, MD 21216</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Crest Lawn Cem</b>   |  | 20c. LOCATION — City or Town, State<br><b>Sykesville, MD</b>   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Dean B. Carl</b>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>March F.H. West<br/>1300 Wabash Ave</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |  |  |   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |  |  |   |  |  |  |
| a. <b>Aspirin Pneumonia</b>   |  |  |  |   |  |  |  |
| b. <b>Carcinoma Colon with</b>  |  |  |  |   |  |  |  |
| c. <b>Metastatic post-surgical</b>  |  |  |  |   |  |  |  |
| d. <b>Metastatic post-surgical</b>  |  |  |  |   |  |  |  |
| 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  |   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office, building, etc. (Specify)<br><b>N/A</b>   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Louis N. Rendell MD</b>   |  |  |  | 29c. LICENSE NUMBER<br><b>D17097</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>October 2, 1990</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><b>Louis N. Rendell MD 2300 Common Blvd. Balto, MD - 21216</b>  |  |  |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 04 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Rendell</b>   |  |  |  |

00375 12



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for use as the burial-transit permit, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |  |   | 90 26981  |  |
|--|--|--|--|--|---|---|--|
| CERTIFICATE OF DEATH   |  |  |  |  |   | REG. NO.  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>PANSY C. GARDNER</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>3</b> YEAR <b>90</b>  |   | 3. TIME OF DEATH<br><b>1:50A</b> M  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>17601 3962</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br><b>90</b> YRS. | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 30, 1899</b>  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Pennsylvania</b> |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>HARBOR HOSPITAL CENTER</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE, MD</b>  |   | 9c. COUNTY OF DEATH   |  |
| 10a. STATE<br><b>Pennsylvania</b>  |  |  |  | 10b. COUNTY<br><b>York</b>   |   | 10c. CITY, TOWN OR LOCATION<br><b>York</b>  |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>656 Company Street</b>  |   | 10f. ZIP CODE<br><b>17404</b>   |  |
| 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>White</b>   |   | 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th grade</b><br>College (1-4 or 5+) <b>College</b>   |  |
| 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Tobacco Stripper</b>  |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Cigar Factory</b>   |   | 17. FATHER'S NAME (First, Middle, Last)<br><b>George Collins</b>  |  |
| 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jane Schmuck</b>   |  |  |  | 19a. INFORMANT'S NAME (Type/Print)<br><b>Wayne Gardner</b>   |   | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>216 Baltimore Street Hanover, Pa. 17331</b>   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Mt. Rose Cemetery 10/6/90</b>   |   | 20c. LOCATION — City or Town, State<br><b>York, Pennsylvania</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Earl L. Pappas</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. 21204</b>   |   | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEVERE SEPSIS</b><br><b>WALDENSTROM'S MACROGLOBULINEMIA</b><br>Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  |
| 28a. DATE OF INJURY (Month, Day, Year)   |  |  |  | 28b. TIME OF INJURY<br><b>M</b>  |   | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |
| 28d. DESCRIBE NOW INJURY OCCURRED  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>HOUSE STAFF</i>  |   | 29c. LICENSE NUMBER<br><b>D 40390</b>   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>10/3/90</b>  |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>P. R. DESAI, MD, HARBOR HOSPITAL CENTER, 3001 B. HANOVER ST., BALTIMORE, MD</b>  |   | 31. DATE FILED (Month, Day, Year)<br><b>OCT 04 1990</b>   |  |
| 32. REGISTRAR'S SIGNATURE<br><i>Julia Dawson</i>   |  |  |  | 33. REGISTRAR'S NAME<br><b>JULIA DAWSON</b>  |   | 34. REGISTRAR'S ADDRESS<br><b>2123</b>  |  |

10-10-1964



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for vital, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26982

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br><b>HENRY NMI GILMORE</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 - 1 - 90</b>   |  | 3. TIME OF DEATH<br><b>0640 A</b>  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>22012154545</b>   |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>64</b> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>10-25-1925</b>  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>SOUTH CAROLINA</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>MD Institute For Emergency Medicine BALTO</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>BALTIMORE</b>  |  |
| 9c. COUNTY OF DEATH<br><b>BALTIMORE</b>   |  |  |  | 10a. STATE<br><b>MARYLAND</b>  |  | 10b. COUNTY<br><b>BALTIMORE</b>  |  |
| 10c. CITY, TOWN OR LOCATION<br><b>BALTIMORE</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>948 SEAGULL AVE</b>   |  |
| 10f. ZIP CODE<br><b>21225</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>1944 - 1946</b>  |  |  |  | 13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  |  |  |
| 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  |  |  | 15. DECEASED'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>12</b>  |  |  |  |
| 16a. DECEASED'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>RETIRED</b>   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>BALTIMORE, CITY</b>   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>GILMORE MAYS GILMORE</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>UNKNOWN ROSE LEE GILMORE</b>   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>IRVING GILMORE</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>SAME 948 SEAGULL AVE, BALTIMORE, MARYLAND 21225</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>CROWNSVILLE V.A. CEMETERY</b>   |  |  |  |
| 20c. LOCATION — City or Town, State<br><b>CROWNSVILLE, MARYLAND</b>   |  |  |  | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  |
| 22. NAME AND ADDRESS OF FACILITY<br><b>ESTEP BROTHERS FUNERAL HOME, P.A.<br/>1300 EUTAW PLACE, BALTIMORE, MD. 21217</b>   |  |  |  | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CLOSED HEAD INJURY</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><br>a. <b>SKULL FRACTURE</b><br>b. <b>SUB DURAL HEMATOMA</b><br>c. <b>CHRONIC DEMENTIA</b><br>d. <b>EDDIA</b><br><br>Approximate Interval Between Onset and Death<br><b>12</b> |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC DEMENTIA</b>   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 25. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  | 26. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  |
| 27a. DATE OF INJURY (Month, Day, Year)  |  |  |  | 27b. TIME OF INJURY<br>M <b>1</b> <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |
| 27c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 27d. DESCRIBE HOW INJURY OCCURED   |  |  |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>  |  |  |  |
| 29c. LICENSE NUMBER<br><b>D40115</b>  |  |  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>10/1/90</b>  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 04 1990</b>   |  |  |  |  |  |  |  |
| 32. REGISTRAR'S SIGNATURE<br>   |  |  |  |  |  |  |  |

2. 2005

(2)

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be completed and filed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |   |  |                                |   |                  |  |  | 90 26983   |  |
|---|--|--|---|--|--------------------------------|---|------------------|--|--|--|--|
| 1 - FOR STATE REGISTRAR   |  |  |   |  |                                |   |                  |  |  | REG. NO.   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |  |   |  |                                |   |                  |  |  | 2. DATE OF DEATH   |  |
| DOROTHY GILLAN  |  |  |   |  |                                |   |                  |  |  | 10/3/90  |  |
| 3. TIME OF DEATH  |  |  |   |  |                                |   |                  |  |  | 0515 A.M.  |  |
| 4. SOCIAL SECURITY NUMBER   |  |  | 5. SEX  |  | 6. AGE (In yrs. last birthday) |   | 7. DATE OF BIRTH |  | 8. BIRTHPLACE (State or Foreign Country)       |  |  |
| 217-26-2789   |  |  | 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F    |  | 77 YRS.                        |   | OCT. 26, 1912    |  | MARYLAND                                       |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)  |  |  |   |  |                                |   |                  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |
| GREATER LAUREL HOSPITAL   |  |  |   |  |                                |   |                  |  |  | LAUREL   |  |
| 9c. COUNTY OF DEATH   |  |  |   |  |                                |   |                  |  |  | PRINCE GEORGE  |  |
| 10a. STATE  |  |  |   |  |                                |   |                  |  |  | 10b. COUNTY  |  |
| MARYLAND  |  |  |   |  |                                |   |                  |  |  | HOWARD   |  |
| 10c. CITY, TOWN OR LOCATION   |  |  |   |  |                                |   |                  |  |  | 10d. INSIDE CITY LIMITS?   |  |
| COLUMBIA  |  |  |   |  |                                |   |                  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 10e. STREET AND NUMBER  |  |  |   |  |                                |   |                  |  |  | 10f. ZIP CODE  |  |
| 10799 HICKORY RIDGE ROAD  |  |  |   |  |                                |   |                  |  |  | 21044  |  |
| 10g. CITIZEN OF WHAT COUNTRY?   |  |  |   |  |                                |   |                  |  |  | U.S.A.   |  |
| 11. MARITAL STATUS  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?                             |  |                                | 13. WAS DECEDENT OF HISPANIC ORIGIN?                                    |                  |  | 14. RACE — American Indian, Black, White, etc. |  |  |
| 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married   |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |                                | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |                  |  | Specify: WHITE                                 |  |  |
| 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  |  | IF YES, GIVE WAR OR DATES   |  |                                | If yes, specify Cuban, Mexican, Puerto Rican, etc.)                     |                  |  | Specify:                                       |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)   |  |  |   |  |                                |   |                  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |
| Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12   |  |  |   |  |                                |   |                  |  |  | HOMEMAKER  |  |
| 16b. KIND OF BUSINESS/INDUSTRY  |  |  |   |  |                                |   |                  |  |  | HOUSEWIFE  |  |
| 17. FATHER'S NAME (First, Middle, Last)   |  |  |   |  |                                |   |                  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |
| ROBERT HUNTT  |  |  |   |  |                                |   |                  |  |  | DORA HEIGER  |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |  |   |  |                                |   |                  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |
| MARILYNN JOHNSON  |  |  |   |  |                                |   |                  |  |  | 4056 FRAGILE SAIL WAY, ELLICOTT CITY, MD. 21043  |  |
| 20a. METHOD OF DISPOSITION  |  |  |   |  |                                |   |                  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)   |  |
| 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State   |  |  |   |  |                                |   |                  |  |  | METRO CREMATORY  |  |
| 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |   |  |                                |   |                  |  |  | 20c. LOCATION — City or Town, State  |  |
|   |  |  |   |  |                                |   |                  |  |  | CATONSVILLE, MD.   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |  |   |  |                                |   |                  |  |  | 22. NAME AND ADDRESS OF FACILITY   |  |
| <i>[Signature]</i>  |  |  |   |  |                                |   |                  |  |  | LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES   |  |
|   |  |  |   |  |                                |   |                  |  |  | 5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  |  |   |  |                                |   |                  |  |  | Approximate Interval Between Onset and Death   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |  |   |  |                                |   |                  |  |  | one wk.  |  |
| a. Pneumonia  |  |  |   |  |                                |   |                  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |   |  |                                |   |                  |  |  |  |  |
| b. Chronic Obstructive Pulmonary Disease  |  |  |   |  |                                |   |                  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |   |  |                                |   |                  |  |  |  |  |
| c.  |  |  |   |  |                                |   |                  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |  |   |  |                                |   |                  |  |  |  |  |
| d.  |  |  |   |  |                                |   |                  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  |  |  |   |  |                                |   |                  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |  |                                |   |                  |  |  | 24a. WAS AN AUTOPSY PERFORMED?   |  |
| Supraventricular tachycardia  |  |  |   |  |                                |   |                  |  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |
| Liver masses  |  |  |   |  |                                |   |                  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  |  |
| Anemia, Atrial arrhythmias  |  |  |   |  |                                |   |                  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  |  |   |  |                                |   |                  |  |  | 26. PLACE OF DEATH (Check only one)  |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |  |   |  |                                |   |                  |  |  | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |
| 27. MANNER OF DEATH   |  |  |   |  |                                |   |                  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  |
| 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation  |  |  |   |  |                                |   |                  |  |  | 28b. TIME OF INJURY  |  |
| 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined  |  |  |   |  |                                |   |                  |  |  | 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  |  |   |  |                                |   |                  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |  |                                |   |                  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)   |  |  |   |  |                                |   |                  |  |  | 29c. LICENSE NUMBER  |  |
| 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                        |  |  |   |  |                                |   |                  |  |  | D37013   |  |
| 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |   |  |                                |   |                  |  |  | 29d. DATE SIGNED (Month, Day, Year)  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |  |   |  |                                |   |                  |  |  | 2744   |  |
| B CONGER MD INTERNIST   |  |  |   |  |                                |   |                  |  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |  |   |  |                                |   |                  |  |  |  |  |
| B CONGER MD SUITE 205 11055 LITTLE PATUXENT PKY COLUMBIA MD   |  |  |   |  |                                |   |                  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)   |  |  |   |  |                                |   |                  |  |  | 32. REGISTRAR'S SIGNATURE  |  |
| OCT 04 1990   |  |  |   |  |                                |   |                  |  |  | <i>[Signature]</i>   |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90-26984

1. FOR  
STATE  
REGISTRAR

|  |  |   |  |  |  |   |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><u>James Henry Harris</u>  |  |   |  | 2. DATE OF DEATH<br>MONTH <u>9</u> DAY <u>29</u> YEAR <u>90</u>  |  | 3. TIME OF DEATH<br>M   |  |   |  |  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><u>223-16-4237</u>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><u>79</u> YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><u>5-10-11</u>                |  | 8. BIRTHPLACE (State or Foreign Country)<br><u>VIRGINIA</u>   |  |  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><u>St. Agnes Hospital</u>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><u>Baltimore</u>  |  |   |  | 9c. COUNTY OF DEATH   |  |  |  |   |  |
| 10a. STATE<br><u>MD</u>  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><u>Baltimore</u>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |  |  |   |  |
| 10e. STREET AND NUMBER<br><u>1218 N. Augusta Avenue</u>  |  |   |  | 10f. ZIP CODE<br><u>21229</u>  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                             |  |   |  |  |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <u>Black</u> |  |   |  |  |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><u>Continental Can Company</u>   |  |   |  |   |  |  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><u>James Harris</u>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><u>Tessie Valley</u>  |  |   |  |   |  |  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><u>Delores Harris</u>  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>1218 N. Augusta Avenue, Baltimore, MD 21229</u>  |  |   |  |   |  |  |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><u>Beulah Baptist Church Cemetery</u>   |  | 20c. LOCATION — City or Town, State<br><u>Lancaster Co., Virginia</u>  |  |   |  |   |  |  |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><u>[Signature]</u>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><u>March Funeral Home-west<br/>4300 Wabash Avenue</u>  |  |   |  |   |  |  |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>SEPSIS</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>PNEUMONIA</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u>ASPIRATION</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <u>ORGANIC BRAIN SYNDROME / BOWEL OBSTRUCTION</u><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |  |  |   |  | Approximate interval Between Onset and Death  |  |  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>COPD, INTRABRACHIAL ABSCESSES,</u><br><u>ABDOMINAL WOUND DEBRISCHE, DISLOCATIONS</u><br><u>FISTULA</u>  |  |   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined |  | 28a. DATE OF INJURY (Month, Day, Year)<br><u>N/A</u>                    |  | 28b. TIME OF INJURY<br><u>M</u>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 28d. DESCRIBE HOW INJURY OCCURRED<br><u>N/A</u> |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><u>[Signature] MD - RESIDENT</u>   |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year)<br><u>9/29/90</u>                   |  |   |  |  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><u>LAMBROS VIGANAS ST AGNES HOSPITAL</u>  |  |   |  |  |  |   |  |   |  |  |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><u>Oct 9 1990</u>   |  |   |  |  |  |   |  |   |  |  |  |   |  |

1000

1000

1000

1000

1000

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use with the funeral permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26985

|   |  |  |  |   |  |   |   |   |  |
|---|--|--|--|---|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Georgia Frederica Howard</i>   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>10-2-1990</i>  |  | 3. TIME OF DEATH<br>M   |   |   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>218-18-9473</i>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>65</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>2-11-25</i>  |   | 8. BIRTHPLACE (State or Foreign Country)<br><i>Maryland</i> |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>6051 Duckett Lane</i>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Elkridge</i>  |  |   | 9c. COUNTY OF DEATH<br><i>Howard</i>  |   |  |
| 10a. STATE<br><i>Maryland</i>   |  | 10b. COUNTY<br><i>Howard</i>   |  | 10c. CITY, TOWN OR LOCATION<br><i>Elkridge</i>  |  |   | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |  |
| 10e. STREET AND NUMBER<br><i>6051 Duckett Lane</i>  |  |  |  | 10f. ZIP CODE<br><i>21227</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A</i>   |   |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>Black</i>                          |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)   |  |   | 16b. KIND OF BUSINESS/INDUSTRY  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Frederick K. H. Stephens</i>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Georgia E. Woolford</i>   |  |   |   |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Mrs. Sidney Howard</i>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>6035 Duckett E/Elkridge Md. 21227</i>   |  |   |   |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Arbutus Mem. Park</i>   |  |   | 20c. LOCATION — City or Town, State<br><i>BALTO. Co. Md.</i> |   |   |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Joseph L. Russ</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Joseph L. Russ Funeral Home<br/>2225 W. North Ave. Balto. Md.</i>  |  |   |   |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic Lung Cancer</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |  |  |   |  |   |   |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |   |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED                           |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Paul E. Gormley MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><i>D8587</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>10/3/90</i>   |   |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>Paul E. Gormley 900 Caton Ave Balto. MD 21229</i>   |  |  |  |   |  |   |   |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>OCT 04 1990</i>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Johanna Davidson-Pandell</i>  |  |   |   |   |  |

1-5-092

1-5-092



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26986

|   |  |   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Lillie Howard</b>  |  |   |  | 2. DATE OF DEATH<br>MONTH <b>10</b> DAY <b>2</b> YEAR <b>90</b>   |  | 3. TIME OF DEATH<br><b>5:50 AM</b>  |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>215-32-1800</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>89</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>10/15/1900</b>                                    |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Maryland</b>   |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Keswick NURSING HOME</b>   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore</b>   |  |   |  | 9c. COUNTY OF DEATH   |  |  |  |
| 10a. STATE<br><b>Maryland</b>   |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><b>4403 Ethland Ave.</b>  |  |   |  | 10f. ZIP CODE<br><b>21207</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>  |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>                  |  | 15b. KIND OF BUSINESS/INDUSTRY  |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Israel Matthews</b>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Martha Fields</b>   |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Doris H. Wallace</b>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4403 Ethland Ave. Baltimore, MD 21207</b>   |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>  |  | 20c. LOCATION — City or Town, State<br><b>Anne Arundel Co., MD</b>  |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Gary L. Folger</b>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Nutter Funeral Homes.<br/>2501 Gwynns Falls Parkway<br/>Baltimore, Maryland 21216</b>  |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Coronary Heart Failure</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>Chronic bronchial asthma - COPD</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c.<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |   |  | Approximate interval Between Onset and Death<br><b>3 years</b><br><b>5 years</b>                      |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  | HOSPITAL:<br><input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA                             |  | 25b. PLACE OF DEATH (Check only one)<br>OTHER:<br><input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                  |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
|   |  | 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>G. Humbert</b>  |  |   |  |   |  | 29c. LICENSE NUMBER<br><b>DMX97</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>10.2.90</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |   |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 4 1990</b>  |  | 32. REGISTRAR'S SIGNATURE<br><b>John Davidson-Rodwell</b>   |  |   |  |   |  |   |  |  |  |

200, 5 10



**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

DHMH-16 Rev 1/89

000000 00

2



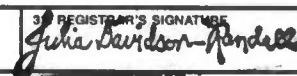
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26988

|   |  |   |  |   |  |  |  |   |  |                               |  |  |  |
|---|--|---|--|---|--|--|--|---|--|-------------------------------|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>John H. Hall  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>10-2-1990   |  |  |  | 3. TIME OF DEATH<br>12:40 P M   |  |                               |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>404-09-1091  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>82 YRS.   |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>4-7-1908                                   |  | 8. BIRTHPLACE (State or Foreign Country)<br>Virginia  |  |                               |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>2802 Orleans St.  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore City   |  |  |  | 9c. COUNTY OF DEATH<br>-- -- --   |  |                               |  |  |  |
| 10a. STATE<br>Md.   |  | 10b. COUNTY<br>-- -- --   |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore City   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |                               |  |  |  |
| 10e. STREET AND NUMBER<br>2802 Orleans St.  |  |   |  | 10f. ZIP CODE<br>21224  |  | 10g. CITIZEN OF WHAT COUNTRY?  |  |   |  |                               |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White   |  |                               |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)<br>unknown   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Truck Driver                       |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Railroad   |  |   |  |                               |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Sank Hall  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Susie Gilbert  |  |  |  |   |  |                               |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Peggy Borkowski   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2802 Orleans St., Balto. Md. 21224   |  |  |  |   |  |                               |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Cedar Hill Cemetery   |  |   |  | 20c. LOCATION — City or Town, State<br>Glen Burnie, Md.                              |  |   |  |                               |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Moran-Ashton Funeral Home, INC.<br>3000 E. Baltimore St., BALTO. Md. 21224  |  |  |  |   |  |                               |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Emphysema</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <u>Diabetes</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <u>CVA</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death  |  |                               |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br><br>  |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |  |                               |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |                               |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURED  |  |                               |  |  |  |
|   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)         |  |   |  |                               |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br> MD             |  | 29c. LICENSE NUMBER<br>D38390 |  | 29d. DATE SIGNED (Month, Day, Year)<br>10-3-1990 |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |   |  |   |  |  |  |   |  |                               |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 04 1990  |  |   |  | 32. REGISTRAR'S SIGNATURE<br>  |  |  |  |   |  |                               |  |  |  |



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26989

|  |  |   |  |   |  |  |  |   |  |   |  |
|--|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>DELORES JACKSON  |  |   |  | 2. DATE OF DEATH<br>SEPTEMBER 28 1990   |  |  |  | 3. TIME OF DEATH<br>11:53 p.m.  |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>213-34-5560   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>52 YRS.   |  | 7. DATE OF BIRTH (Month/Day, Year)<br>12/29/37                                       |  | 8. BIRTHPLACE (State or Foreign Country)<br>WASH. D.C.  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL   |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTIMORE CITY   |  |  |  | 9c. COUNTY OF DEATH<br>BALTIMORE CITY   |  |   |  |
| RESIDENCE OF DECEDENT  |  |   |  |   |  |  |  |   |  |   |  |
| 10a. STATE<br>Md.  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br>BALTO.   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |   |  |
| 10e. STREET AND NUMBER<br>2021 Mc ELDerry ST   |  |   |  | 10f. ZIP CODE<br>21205  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: BLACK                     |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Secondary<br>College (1-4 or 5+) College  |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>J.H. Hosp.   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>CHARLES BRANCH Jr   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)   |  |  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Jerry Branch   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2635 Ashland Rd Balto, Md. 21205   |  |  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>MT. PALMERY CEM   |  | 20c. LOCATION — City or Town, State<br>A.A. County, Md  |  |  |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Joseph B. Locke Jr  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Locke Funeral Home 1304 N. Central Ave  |  |  |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial infarction<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br>1 h   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Diverticular bleeding, recent left hemicolectomy (approx. 18 days ago)   |  |   |  |   |  |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO      |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |   |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>C. E. Wolfe MD  |  |   |  | 29c. LICENSE NUMBER<br>D 33210  |  | 29d. DATE SIGNED (Month, Day, Year)<br>9/29/90                                       |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>600 N. WOLFE ST. BALTIMORE MD 21205   |  |   |  |   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>9/OCT 04 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>John Davidson-Randall  |  |  |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 1046,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed by the attending physician within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

50-100-100

3



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for registration, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR  |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 90 26990  |  |   |  |  |  |
|--|--|--|--|--|--|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.   |  |   |  |   |  |   |  |  |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Melba Marie Johnson  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>10-3-1990  |  |   |  | 3. TIME OF DEATH<br>3:45 P M  |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>223-18-2929   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>73 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                      |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>7/2/17   |  | 8. BIRTHPLACE (State or Foreign Country)<br>North Carolina   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Francis Scott Key Medical Center   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore   |  |   |  | 9c. COUNTY OF DEATH   |  |   |  |  |  |
| 10a. STATE<br>MD   |  | 10b. COUNTY<br>Baltimore   |  | 10c. CITY, TOWN OR LOCATION  |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |   |  |  |  |
| 10e. STREET AND NUMBER<br>3403 Loganview Drive   |  |  |  | 10f. ZIP CODE<br>21222   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA  |  |   |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WW II Army |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>white                               |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5 +)<br>unknown  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>employee                                    |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>clothing business |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John A. Hill  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Crystal D. Johnson  |  |   |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Hollomon-Brown Funeral Home  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>8464 Tidewater Dr/Norfolk, VA 23518   |  |   |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Forest Lawn Cemetery   |  | 20c. LOCATION — City or Town, State<br>Norfolk, VA   |  |   |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>[Signature]   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Bradley-Ashton Funeral Home Inc.<br>2134 Willow Spring Rd. Dundalk, Md. 21222  |  |   |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Squamous cell Cancer of Lung<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF):<br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |  |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death<br>1 yr   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M                            |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO              |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                      |  |   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |  |   |  |   |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>[Signature] MD  |  |  |  | 29c. LICENSE NUMBER<br>D36430  |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br>10/3/90  |  |   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Jeff Anderson MD 2112 Dundalk, Dundalk MD 21222   |  |  |  |  |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 04 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |  |   |  |   |  |  |  |

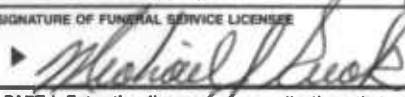

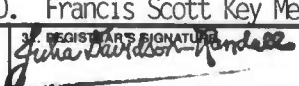


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26991

|   |  |  |  |   |  |   |   |  |   |  |
|---|--|--|--|---|--|---|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>LEOTA M. KNOTTS   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>October 1, 1990   |  | 3. TIME OF DEATH<br>11:50 P. M                      |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>232-58-3162  |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>XX 52 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>10-3-1937 |   | 8. BIRTHPLACE (State or Foreign Country)<br>W. Va. |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Francis Scott Key Medical Center  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Baltimore  |  |   | 9c. COUNTY OF DEATH   |  |   |  |
| 10a. STATE<br>Maryland  |  |  |  | 10b. COUNTY<br>Baltimore  |  |   | 10c. CITY, TOWN OR LOCATION<br>Baltimore                            |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br>3526 E. Baltimore Street  |  |  |  | 10f. ZIP CODE<br>21224  |  |   | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                             |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  |   | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>12 Yrs. College (1-4 or 5+)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Cook   |  |   | 16b. KIND OF BUSINESS/INDUSTRY<br>White Coffee Pot/ Fast Foods      |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Lafayette Knotts   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Ronald Freeland  |  |   |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Ronald Funk   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Rt 2, Box 183B, Tunnelton, W.Va. 26444   |  |   |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Mt. Israel Cemetery 10-5-90  |  | 20c. LOCATION — City or Town, State<br>Preston Co. W.Va.  |  |   |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Leonard J. Ruck, Inc. 5305 Harford Road 21214   |  |   |   |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>LUNG CANCER</u><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b.<br>c.<br>d.<br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br><br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br><br>25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br><br>26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)<br><br>27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br><br>28a. DATE OF INJURY (Month, Day, Year)<br>28b. TIME OF INJURY<br>M<br>28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>28d. DESCRIBE HOW INJURY OCCURRED<br><br>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |  |  |   |  |   |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><br>29b. SIGNATURE AND TITLE OF CERTIFIER<br> M.D.<br>29c. LICENSE NUMBER<br>D19714<br>29d. DATE SIGNED (Month, Day, Year)<br>October 2, 1990  |  |  |  |   |  |   |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Michael J. Purtell, M.D. Francis Scott Key Medical Center  |  |  |  |   |  |   |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 04 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>  |  |   |   |  |   |  |

10.1.77



201

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for filing, registration, and removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR  |  |          |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE                                   |  |                  |  | 90 26992   |  |  |  |
|---|--|----------|--|---|--|------------------|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)  |  |          |  | 2. DATE OF DEATH  |  |                  |  | 3. TIME OF DEATH   |  |  |  |
| Frederick Charles Knauf   |  |          |  | 10 1 90   |  |                  |  | 1904 P M   |  |  |  |
| 4. SOCIAL SECURITY NUMBER   |  | 5. SEX   |  | 6. AGE (In yrs. last birthday)  |  | 7. DATE OF BIRTH |  | 8. BIRTHPLACE (State or Foreign Country)   |  |  |  |
| 128-01-6809   |  | XX M 2 F |  | 86 YRS.   |  | 3/29/04          |  | New York   |  |  |  |
| 9a. RESIDENCE NAME (If not institution, give street and number)   |  |          |  | 9b. CITY, TOWN OR LOCATION OF DEATH   |  |                  |  | 9c. COUNTY OF DEATH  |  |  |  |
| St. Agnes Hospital  |  |          |  | Baltimore   |  |                  |  |  |  |  |  |
| 10a. STATE  |  |          |  | 10b. COUNTY   |  |                  |  | 10c. CITY, TOWN OR LOCATION  |  |  |  |
| NY  |  |          |  |   |  |                  |  | Owego  |  |  |  |
| 10d. INSIDE CITY LIMITS?  |  |          |  | 10e. STREET AND NUMBER  |  |                  |  | 10f. ZIP CODE  |  |  |  |
| XXX YES 2 NO  |  |          |  | 38 Knauf Road   |  |                  |  | 13827  |  |  |  |
| 10g. CITIZEN OF WHAT COUNTRY?   |  |          |  | 11. MARITAL STATUS  |  |                  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |  |  |  |
| USA   |  |          |  | 1. Never Married 2. Married<br>XX Widowed 4. Divorced   |  |                  |  | 1. YES 2. NO<br>IF YES, GIVE WAR OR DATES  |  |  |  |
| 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)   |  |          |  | 14. RACE — American Indian, Black, White, etc.  |  |                  |  | 15. DECEDENT'S EDUCATION   |  |  |  |
| 1. YES 2. NO  |  |          |  | Specify:  |  |                  |  | Specify kind of work done during most of working life. Do NOT use retired.                               |  |  |  |
| white   |  |          |  |   |  |                  |  | Elementary/Secondary (0-12) College (1-4 or 5+)  |  |  |  |
| unknown   |  |          |  | optician  |  |                  |  | family business  |  |  |  |
| 16. KIND OF BUSINESS/INDUSTRY   |  |          |  | 17. FATHER'S NAME (First, Middle, Last)   |  |                  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |  |  |
|   |  |          |  | Frederick Charles Knauf   |  |                  |  | Ethel L. Whalen  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)  |  |          |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |  |                  |  |  |  |  |  |
| Charles Knauf   |  |          |  | 521 Nottingham Road/Balto. MD 21229   |  |                  |  |  |  |  |  |
| 20a. METHOD OF DISPOSITION  |  |          |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)                        |  |                  |  | 20c. LOCATION — City or Town, State  |  |  |  |
| 1. Burial 2. Cremation 3. Removal from State<br>4. Donation 5. Other (Specify)  |  |          |  | Chenango Valley Cemetery  |  |                  |  | Broome Co., NY   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE   |  |          |  | 22. NAME AND ADDRESS OF FACILITY  |  |                  |  |  |  |  |  |
| Poland P. Stach   |  |          |  | Sterling Ashton Funeral Home, Inc.<br>736 Edmondson Ave/Balto. MD 21228                       |  |                  |  |  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |  |          |  |   |  |                  |  | Approximate Interval Between Onset and Death   |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →   |  |          |  |   |  |                  |  | 70 MIN   |  |  |  |
| a. MALIGNANT ARYTHMIA   |  |          |  |   |  |                  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |          |  |   |  |                  |  |  |  |  |  |
| b. METASTATIC COLORECTAL  |  |          |  |   |  |                  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |          |  |   |  |                  |  |  |  |  |  |
| c. (2) INTERMITTENT FIBROSIS  |  |          |  |   |  |                  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):  |  |          |  |   |  |                  |  |  |  |  |  |
| d.  |  |          |  |   |  |                  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |          |  |   |  |                  |  | 24a. WAS AN AUTOPSY PERFORMED?   |  |  |  |
| ATRIAL FIBRILLATION<br>CONGESTIVE HEART FAILURE   |  |          |  |   |  |                  |  | 1. YES 2. NO   |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?  |  |          |  |   |  |                  |  | 26. PLACE OF DEATH (Check only one)  |  |  |  |
| 1. YES 2. NO  |  |          |  |   |  |                  |  | HOSPITAL: 1. Inpatient 2. ER/Outpatient 3. DOA<br>OTHER: 4. Nursing Home 5. Residence 6. Other (Specify) |  |  |  |
| 27. MANNER OF DEATH   |  |          |  |   |  |                  |  | 28a. DATE OF INJURY  |  |  |  |
| 1. Natural 2. Accident 3. Suicide 4. Homicide 5. Pending Investigation 6. Could not be determined   |  |          |  |   |  |                  |  | (Month, Day, Year)   |  |  |  |
|   |  |          |  |   |  |                  |  | 28b. TIME OF INJURY  |  |  |  |
|   |  |          |  |   |  |                  |  | 2009 M   |  |  |  |
|   |  |          |  |   |  |                  |  | 28c. INJURY AT WORK?   |  |  |  |
|   |  |          |  |   |  |                  |  | 1. YES 2. NO   |  |  |  |
|   |  |          |  |   |  |                  |  | 28d. DESCRIBE NOW INJURY OCCURRED  |  |  |  |
|   |  |          |  |   |  |                  |  | SLIPPED + FELL   |  |  |  |
|   |  |          |  |   |  |                  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)                   |  |  |  |
|   |  |          |  |   |  |                  |  | HOME   |  |  |  |
|   |  |          |  |   |  |                  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)                             |  |  |  |
|   |  |          |  |   |  |                  |  | 521 NOTTINGHAM   |  |  |  |
| 29a. CERTIFIER (Check only one)   |  |          |  |   |  |                  |  | 29b. LICENSE NUMBER  |  |  |  |
| 1. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |          |  |   |  |                  |  |  |  |  |  |
| 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.                           |  |          |  |   |  |                  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER   |  |          |  |   |  |                  |  | 29c. DATE SIGNED (Month, Day, Year)  |  |  |  |
| M. J. Stach   |  |          |  |   |  |                  |  | 10/1/90  |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)   |  |          |  |   |  |                  |  |  |  |  |  |
| GREGG WOLFE 738 MCHENRY ST BALTO, MD 21230  |  |          |  |   |  |                  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)   |  |          |  |   |  |                  |  | 32. REGISTRAR'S SIGNATURE  |  |  |  |
| 10 OCT 04 1990  |  |          |  |   |  |                  |  | Julia Davidson-Rendall   |  |  |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for burial, cremation, or removal.

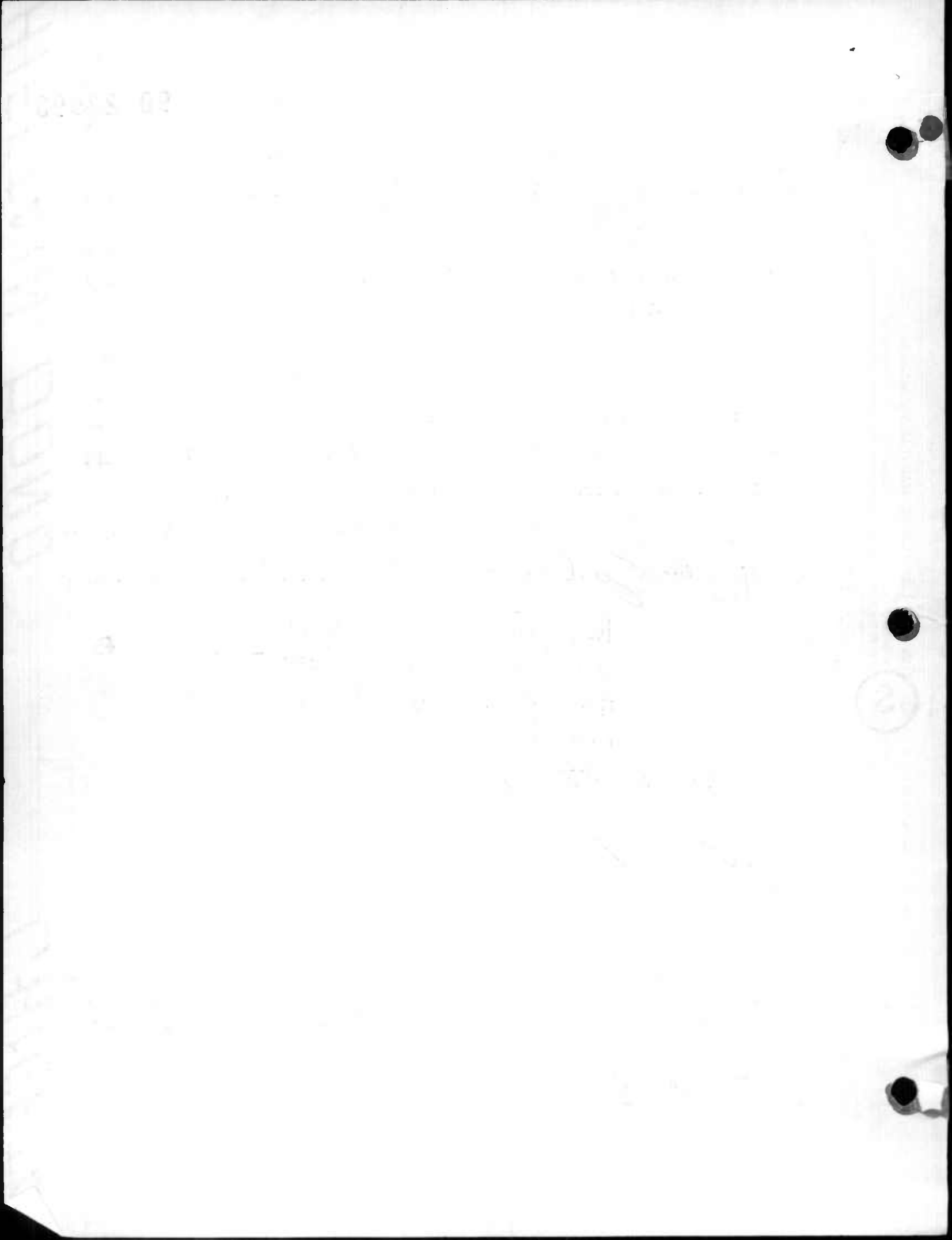
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26993

|  |  |  |  |   |  |  |                                     |   |  |   |  |
|--|--|--|--|---|--|--|-------------------------------------|---|--|---|--|
| 1. DECEASED'S NAME (First, Middle, Last)<br>MARGARET ANNA KEEGAN   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>OCT. 02 90  |  | 3. TIME OF DEATH<br>700 P M  |                                     |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>213-05-3261 A   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>78 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Aug. 23 1912                                  |                                     | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>NORTH ARUNDEL HOSPITAL HOSPITAL DRIVE  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>GLEN BURNIE MARYLAND   |  |  | 9c. COUNTY OF DEATH<br>ANNE ARUNDEL |   |  |   |  |
| 10a. STATE<br>Maryland   |  |  |  | 10b. COUNTY<br>Anne Arundel   |  | 10c. CITY, TOWN OR LOCATION<br>Glen Burnie   |                                     | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |   |  |
| 10e. STREET AND NUMBER<br>902 Palm Tree Circle   |  |  |  | 10f. ZIP CODE<br>21060  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>USA   |                                     |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                     |                                     |   |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>8th  |  | 15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  | 15b. KIND OF BUSINESS/INDUSTRY<br>Own Home  |  |  |                                     |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Jakubowski   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Nellie Cahall  |  |  |                                     |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>William F. Keegan, Sr.   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same as 10   |  |  |                                     |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Glen Haven Memorial Park   |  | 20c. LOCATION — City or Town, State<br>Glen Burnie, Maryland  |  |  |                                     |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>SINGLETON FUNERAL HOME<br>1 SECOND AVE. S.W., GLEN BURNIE, MD. 21061  |  |  |                                     |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. <i>Aspiration pneumonia</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <i>Cerebrovascular accident</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <i>Amyotrophic lateral sclerosis</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <i>Renal failure</i><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  |                                     | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>pneumothorax</i>  |  |  |  |   |  |  |                                     | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO      |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |                                     |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                     | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>[Signature]</i>  |  |   |  | 29c. LICENSE NUMBER<br>036256  |                                     | 29d. DATE SIGNED (Month, Day, Year)<br>10/3/90  |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>DR. JORGE M. RAMIREZ MD 7845 OAKWOOD ROAD GLEN BURNIE MARYLAND 21051  |  |  |  |   |  |  |                                     |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 04 1990   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |  |                                     |   |  |   |  |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death of a person be reported within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other significant event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26994

|  |  |  |  |   |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Mary C. Livermon</i>  |  |  |  | 2. DATE OF DEATH<br>MONTH <i>10</i> DAY <i>2</i> YEAR <i>90</i>   |  |   |  | 3. TIME OF DEATH<br><i>9:45 A M</i>   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br><i>214-63-1833</i>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><i>83</i> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><i>12/19/06</i> |  | 8. BIRTHPLACE (State or Foreign Country)<br><i>Massachusetts</i>                                |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>St. Joseph Hospital</i>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Towson</i>  |  |   |  | 9c. COUNTY OF DEATH<br><i>Baltimore</i>   |  |   |  |
| RESIDENCE OF DECEDENT  |  |  |  |   |  |   |  |   |  |   |  |
| 10a. STATE<br><i>Maryland</i>  |  | 10b. COUNTY<br><i>Baltimore</i>  |  | 10c. CITY, TOWN OR LOCATION<br><i>Towson</i>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |   |  |
| 10e. STREET AND NUMBER<br><i>2300 Dulaney Valley Road</i>  |  |  |  | 10f. ZIP CODE<br><i>21204</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>            |  |   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:   |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><i>White</i>                      |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12 yrs.</i><br>College (1-4 or 5+) <i></i>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Secretary</i>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Clerical</i>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>Coleman Greene</i>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Mary Ellen Callahan</i>   |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Barbara Livermon</i>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>7411 Prince George Road Baltimore, Md. 21208</i>  |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Most Holy Redeemer Cem. 10/5/90</i>  |  |   |  | 20c. LOCATION — City or Town, State<br><i>Baltimore, Maryland</i>                               |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>[Signature]</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><i>1050 York Road<br/>Ruck Towson Funeral Home, Inc. Towson, Md. 21204</i>  |  |   |  |   |  |   |  |
| 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia with sepsis</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><i>Congestive heart failure</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Approximate interval Between Onset and Death |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input type="checkbox"/> NO      |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)   |  | 28b. TIME OF INJURY<br><i>M</i>                           |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO                |  | 28d. DESCRIBE HOW INJURY OCCURED  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Natividad D. de Leon, M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><i>D19508</i>  |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>10/2/90</i>   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>NATIVIDAD D. DE LEON, 10 ST. JOSEPH HOSPITAL, TOWSON, MD. 21204</i>  |  |  |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>OCT 04 1990</i>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1000000000



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 90 26995   |  |                                     |  |   |  |
|--|--|--|--|--|--|--|--|--|--|-------------------------------------|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)   |  |  |  | 2. DATE OF DEATH   |  |  |  | 3. TIME OF DEATH   |  |                                     |  |   |  |
| JOSEPH Frank Lesniewski  |  |  |  | Oct. 02 90   |  |  |  | 300 P M  |  |                                     |  |   |  |
| 4. SOCIAL SECURITY NUMBER  |  | 5. SEX   |  | 6. AGE (In yrs. last birthday)   |  | 7. DATE OF BIRTH   |  | 8. BIRTHPLACE (State or Foreign Country)                     |  |                                     |  |   |  |
| 217-14-9341  |  | 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F                                     |  | 66 YRS.  |  | 1-22-24  |  | Baltimore Md.  |  |                                     |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH  |  |  |  | 9c. COUNTY OF DEATH  |  |                                     |  |   |  |
| NORTH ARUNDEL HOSPITAL HOSPITAL DRIVE  |  |  |  | GLEN BURNIE MARYLAND   |  |  |  | ANNE ARUNDEL   |  |                                     |  |   |  |
| 10a. STATE   |  |  |  | 10b. COUNTY  |  |  |  | 10c. CITY, TOWN OR LOCATION                                  |  |                                     |  | 10d. INSIDE CITY LIMITS?  |  |
| Md.  |  |  |  | Anne Arundel   |  |  |  | Glen Burnie  |  |                                     |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER   |  |  |  | 10f. ZIP CODE  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?                                |  |                                     |  |   |  |
| 604 Second Ave. S.W.   |  |  |  | 21061  |  |  |  | U.S.A.   |  |                                     |  |   |  |
| 11. MARITAL STATUS   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN?   |  | 14. RACE — American Indian, Black, White, etc.                               |  |  |  |                                     |  |   |  |
| 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  | Specify: White   |  |  |  |                                     |  |   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)   |  |  |  | 16b. KIND OF BUSINESS/INDUSTRY                               |  |                                     |  |   |  |
| Elementary/Secondary (0-12) College (1-4 or 5+)  |  |  |  | Chief Clerk (Ret)  |  |  |  | I.L.A.   |  |                                     |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)  |  |  |  |  |  |                                     |  |   |  |
| Peter Lesniewski   |  |  |  | Emilia Chaskiewicz   |  |  |  |  |  |                                     |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |  |  |  |  |  |                                     |  |   |  |
| Theresa F. Lesniewski  |  |  |  | 604 Second Ave. S.W. Glen Burnie Md. 21061   |  |  |  |  |  |                                     |  |   |  |
| 20a. METHOD OF DISPOSITION   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)                                   |  | 20c. LOCATION — City or Town, State  |  |  |  |  |  |                                     |  |   |  |
| 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | Holy Cross Cemetery  |  | Brooklyn Md.   |  |  |  |  |  |                                     |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE  |  |  |  | 22. NAME AND ADDRESS OF FACILITY   |  |  |  |  |  |                                     |  |   |  |
| [Signature]  |  |  |  | Singleton Funeral Home<br>1 Second Ave S.W. Glen Burnie  |  |  |  |  |  |                                     |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |  |  |                                     |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) →  |  |  |  |  |  |  |  |  |  |                                     |  |   |  |
| a. Hypoxic Encephalopathy 2 days   |  |  |  |  |  |  |  |  |  |                                     |  |   |  |
| b. Ventricular Fibrillation 2 days   |  |  |  |  |  |  |  |  |  |                                     |  |   |  |
| c. Hypertensive Anterior Myocardial Infarction 15 yrs.   |  |  |  |  |  |  |  |  |  |                                     |  |   |  |
| d. Vascular disease  |  |  |  |  |  |  |  |  |  |                                     |  |   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST   |  |  |  |  |  |  |  |  |  |                                     |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |  |  |                                     |  |   |  |
| Polycystic Kidney Disease<br>Thoracic Aneurysm<br>Aortic Abdominal Aneurysm  |  |  |  |  |  |  |  |  |  |                                     |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?   |  |  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?  |  |  |  |  |  |                                     |  |   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |                                     |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?   |  |  |  | 26. PLACE OF DEATH (Check only one)  |  |  |  |  |  |                                     |  |   |  |
| 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |                                     |  |   |  |
| 27. MANNER OF DEATH  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY  |  | 28c. INJURY AT WORK?   |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  |
| 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |  |  |  |  | M  |  | 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |                                     |  |   |  |
|  |  |  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |  |  |  |                                     |  |   |  |
| 29a. CERTIFIER (Check only one)  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER  |  |  |  | 29c. LICENSE NUMBER  |  | 29d. DATE SIGNED (Month, Day, Year) |  |   |  |
| 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | [Signature]  |  |  |  | D31744   |  | 10-2-90                             |  |   |  |
| 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |  |  |  |  |  |  |                                     |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  |  |  |  |  |  |  |  |  |  |                                     |  |   |  |
| DR. G. HAROLD HEBARD M.D. 1600 CRAIN HIGHWAY S.W. GLEN BURNIE MARYLAND 21061   |  |  |  |  |  |  |  |  |  |                                     |  |   |  |
| 31. DATE FILED (Month, Day, Year)  |  |  |  | 32. REGISTRAR'S SIGNATURE  |  |  |  |  |  |                                     |  |   |  |
| OCT 04 1990  |  |  |  | [Signature]  |  |  |  |  |  |                                     |  |   |  |

21ngleton Funeral Home  
1 Second Ave S.W. Glen Burnie

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other public event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 26996

|  |  |   |  |  |  |   |  |   |  |   |  |   |  |  |  |
|--|--|---|--|--|--|---|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Anna Lenert</b>   |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>10 03 90</b>  |  |   |  | 3. TIME OF DEATH<br><b>03:15 PM</b>   |  |   |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>212-07-3502</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><b>86</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>03/21/1904</b>             |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Md.</b>  |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Mercy Medical Center</b>  |  |   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Baltimore CITY</b>  |  |   |  |   |  | 9c. COUNTY OF DEATH   |  |  |  |
| 10a. STATE<br><b>Md.</b>   |  |   |  | 10b. COUNTY  |  |   |  | 10c. CITY, TOWN OR LOCATION<br><b>Baltimore City</b>  |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><b>611 S. Charles St.</b>  |  |   |  |  |  | 10f. ZIP CODE<br><b>21230</b>   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                          |  |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>Cauc.</b> |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Unk.</b><br>College (1-4 or 5+) <b>Unk.</b>   |  |   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Housewife</b>  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Domestic</b>   |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>William Killiam</b>  |  |   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Elizabeth Fucha</b>   |  |   |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Charles Lenert</b>  |  |   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>418 N. Milton Ave. Baltimore, Md. 21224</b>   |  |   |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Holy Redeemer Cemetery</b>  |  |   |  | 20c. LOCATION — City or Town, State<br><b>Baltimore, Md.</b>                                |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Benjamin Chabowski</i>   |  |   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>2818 E. Baltimore St.<br/>B. Dabrowski &amp; Son Baltimore, Md. 21224</b>  |  |   |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrest</b><br><br>Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>a. <b>Chronic emphysema</b><br>b. <b>Arteriosclerosis</b><br>c. <b>Myocardial infarction</b><br>d. <b>Myocardial infarction</b><br><br>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Organic brain syndrome</b><br><b>Dementia senilis</b> |  |   |  |  |  |   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED                                       |  |   |  |  |  |
| 29a. CERTIFIER<br>(Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dr. [Signature]</i>   |  |   |  | 29c. LICENSE NUMBER<br><b>118846</b>                                    |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>10-3-90</b>   |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>844 Dr. [Signature] Auto [Signature] 21207</b>   |  |   |  |  |  |   |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 04 1990</b>  |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |  |   |  |   |  |   |  |   |  |  |  |

10/20/2000

10/20/2000 10:00 AM  
10/20/2000 10:00 AM  
10/20/2000 10:00 AM



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician, TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be delivered to the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 90 26997  |  |   |  |
|--|--|---|--|--|--|---|--|---|--|---|--|
| 1 - CERTIFICATE OF DEATH   |  |   |  | REG. NO.   |  |   |  |   |  |   |  |
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Florence MACBURNEY (A.K.A. Florence K. MacBurney)  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>October 4, 1990  |  |   |  | 3. TIME OF DEATH<br>3:57 A.M.   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>212 09 9380   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br>92 YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br>July 4 1898               |  | 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Franklin Square Hospital Center  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Rossville 21237   |  |   |  | 9c. COUNTY OF DEATH<br>Baltimore  |  |   |  |
| 10a. STATE<br>Maryland   |  |   |  | 10b. COUNTY<br>Baltimore   |  | 10c. CITY, TOWN OR LOCATION<br>Essex                                |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |
| 10e. STREET AND NUMBER<br>300 Torner Road  |  |   |  | 10f. ZIP CODE<br>21221   |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>White |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8<br>College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Housewife                          |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Home   |  |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Peter S. Kell   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Mary ?  |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Graham K. McBurney (SON)   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>300 Torner Road Baltimore Maryland 21221  |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Parkwood Cemetery   |  | 20c. LOCATION — City or Town, State<br>Baltimore County Maryland   |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Bruzdinski Funeral Home P.A. 21221<br>1407 Old Eastern ave Baltimore Maryland  |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Renal Failure<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Pneumonia  |  |   |  |  |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 8 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  |   |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M  |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                      |  | 28d. DESCRIBE NOW INJURY OCCURRED   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br>M. G. Honig M.D.  |  |   |  | 29c. LICENSE NUMBER   |  | 29d. DATE SIGNED (Month, Day, Year)<br>10/4/90  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Marc Honig, M.D. 9000 Franklin Sq. DR., Balto. 21237  |  |   |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>OCT 04 1990   |  |   |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall  |  |   |  |   |  |   |  |

TELETYPE



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90-26998

|  |  |  |  |   |  |   |  |   |  |  |  |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Ruth Valetta Myers</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>9</b> DAY <b>30</b> YEAR <b>90</b> TIME OF DEATH <b>3:40 P.M.</b>  |  |   |  |   |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br><b>214-09-7109</b>  |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>74</b> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>9-12-1916</b>                                     |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Hagerstown, Md</b>                                     |  |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington County Hospital</b>  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Hagerstown, md</b>  |  |   |  | 9c. COUNTY OF DEATH<br><b>Washington</b>  |  |  |  |
| 10a. STATE<br><b>md.</b>   |  | 10b. COUNTY<br><b>Washington</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Hagerstown, Md.</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |  |  |
| 10e. STREET AND NUMBER<br><b>711 Oak Hill Ave</b>  |  |  |  | 10f. ZIP CODE<br><b>21740</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>                                       |  |   |  |  |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |   |  |  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br><b>12th</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Waitress</b>                |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Restaurant</b>   |  |   |  |   |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>J. Edgar Beckley Sr.</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Myrtle Craybill Beckley</b>   |  |   |  |   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Dorothy Beckley</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1437 Salem Ave Hagerstown, Md 21740</b>   |  |   |  |   |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Maryland Anatomical Board</b>                                   |  | 20c. LOCATION — City or Town, State<br><b>Maryland</b>  |  |   |  |   |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><b>Donald M. Weller 10-2-90</b>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>State Anatomy Board Balto. Md.</b>   |  |   |  |   |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Large Cell Carcinoma of the 5 months</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br><b>Left lung</b> |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Obstructive pulmonary disease</b>   |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | HOSPITAL:<br><input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA               |  | 26. PLACE OF DEATH (Check only one)<br>OTHER:<br><input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                          |  |   |  |   |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |  |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><b>Robert Brull Personal Physician</b>   |  |   |  | 29c. LICENSE NUMBER<br><b>004358</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>9/30/90</b>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br><b>Robert Brull MD 1459 Potomac Ave. Hagerstown</b>  |  |  |  |   |  |   |  |   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>OCT 4 - 1990</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><b>Shelia Davidson-Randall</b>   |  |   |  |   |  |  |  |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for filing, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90-26999

|   |  |  |  |   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>JOHN WESLEY METTEE, JR.<br>JOHN WESLEY METTEE JR  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>10 2 90   |  | 3. TIME OF DEATH<br>2 AM  |   |
| 4. SOCIAL SECURITY NUMBER<br>217-12-6579  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>68 YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br>April 25, 1922   |   |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Good Samaritan Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>BALTO CITY   |  | 9c. COUNTY OF DEATH   |   |
| 10a. STATE<br>Maryland  |  | 10b. COUNTY  |  | 10c. CITY, TOWN OR LOCATION<br>Baltimore  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 10e. STREET AND NUMBER<br>6429 Walther Ave. Apt. F  |  | 10f. ZIP CODE<br>21206   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |   |   |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                    |   |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 yr's<br>College (1-4 or 5+)   |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Artist                             |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Self-Employed   |  |   |   |
| 17. FATHER'S NAME (First, Middle, Last)<br>John Wesley Mettee   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Clara Kohrs  |  |   |   |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. William K. Mettee   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3118 Rosalie Ave. Baltimore, Md. 21234   |  |   |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Parkwood 10/6/90   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Md.   |  |   |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Paul L. Hartsock, Jr.  |  | 22. NAME AND ADDRESS OF FACILITY<br>Baltimore, Md. 21214<br>Leonard J. Ruck, Inc. 5305 Harford Rd.   |  |   |  |   |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) →<br>a. Myocardial Infarction<br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. Thoracotomy, left (open lung) 10/1/90 at 3-4 pm<br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. biopsy - to find out primary<br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. of metastatic brain tumor |  |  |  |   |  |   | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>COPD Hypertension<br>Recurring TIA's<br>(Discussed & ME released @ 2:30 am on 10/1/90)  |  |  |  |   |  |   | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO                                   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  |   |  |   | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined<br>4 <input type="checkbox"/> Homicide   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO                |   |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Juan G. Gan, M.D.  |  |  |  | 29c. LICENSE NUMBER<br>D09270   |  | 29d. DATE SIGNED (Month, Day, Year)<br>10/2/90  |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>JUAN G GAN, MD, Good Samaritan Hospital  |  |  |  |   |  |   |   |
| 31. DATE FILED (Month, Day, Year)<br>OCT 04 1990  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Davidson-Randall   |  |   |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

90 27000

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><i>Rose M. McDonough</i>  |  |   |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><i>10 2 90</i>  |  | 3. TIME OF DEATH<br><i>5:05 AM</i>  |  |
| 4. SOCIAL SECURITY NUMBER<br><i>213-03-9242</i>   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 6. AGE (In yrs. last birthday)<br><i>81</i> YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br><i>9/2/09</i>  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><i>Maxwell Care Town</i>  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><i>Towson</i>  |  | 9c. COUNTY OF DEATH<br><i>Balt</i>  |  |
| 10a. STATE<br><i>Md.</i>  |  | 10b. COUNTY   |  | 10c. CITY, TOWN OR LOCATION<br><i>Baltimore City</i>  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| 10e. STREET AND NUMBER<br><i>3109 Dillon Street</i>   |  |   |  | 10f. ZIP CODE<br><i>21224</i>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |
| 11. MARITAL STATUS<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <i>White</i>                             |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>10</i><br>College (1-4 or 5+) <i>College</i>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><i>Comptometer Operator</i>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><i>Essex Corp.</i>  |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><i>John J. McDonough</i>   |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><i>Margaret M. McHugh</i>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><i>Margaret Lubertine</i>   |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>808 S. Clinton St. Balto., Md. 21224</i>  |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)<br><i>Most Holy Redeemer Cemetery</i>  |  | 20c. LOCATION — City or Town, State<br><i>Balto., Md.</i>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Charles S. Zeiler</i>   |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br><i>Charles S. Zeiler &amp; Son Inc. 901 S. Conkling St.</i>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Carcinoma of sigmoid colon</i><br>DUE TO (OR AS A CONSEQUENCE OF):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. DUE TO (OR AS A CONSEQUENCE OF): |  |   |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO   |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY (Month, Day, Year)  |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO     |  |
| 28d. DESCRIBE HOW INJURY OCCURRED   |  |   |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Melito M. Torres</i>  |  |   |  | 29c. LICENSE NUMBER<br><i>0011150</i>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><i>Oct 4 1990</i>  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><i>MELITO M. TORRES, MD 441 S. ELLWOOD AVE, BALTO, MD 21224</i>  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><i>OCT 04 1990</i>   |  |   |  | 32. REGISTRAR'S SIGNATURE<br><i>Jane Davidson-Randall</i>   |  |   |  |

Rose Mc Donough

Md.

x

Baltimore City

Md.

U.S.A.

21254

3109 Dillon Street

x

x

x

White

Comptometer Operator

10

Margaret M. Mc Hugh

John J. Mc Donough

808 2 Clinton St. Balto., Md. 21224

Margaret Lubertine

x

Most Holy Redeemer Cemetery Balto., Md.

Charles S. Zeiler & Son Inc  
2109 2nd St. Contingent

Charles S. Zeiler